

SECTION I – STATE INFORMATION

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

X 2012 – 2013

STATE NAME: Maryland
DUNS#: 135218621

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Health and Mental Hygiene
ORGANIZATIONAL UNIT: Mental Hygiene Administration
STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building
CITY: Catonsville STATE: MD ZIP: 21228
TELEPHONE: 410-402-8473 FAX: 410-402-8309

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Joshua M. Sharfstein TITLE: Secretary
AGENCY: Department of Health and Mental Hygiene
ORGANIZATIONAL UNIT: Office of the Secretary
CITY: Baltimore STATE: MD ZIP: 21201
TELEPHONE: 410-767-6505 FAX: 410-767-6489

III. STATE FISCAL YEAR

FROM: July 2011 TO: June 2013
Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Cynthia Petion TITLE: Director, Office of Planning, Evaluation and Training
AGENCY: Department of Health and Mental Hygiene
ORGANIZATIONAL UNIT: Mental Hygiene Administration
STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building
CITY: Catonsville STATE: MD ZIP: 21228
TELEPHONE: 410-402-8473 FAX: 410-402-8309 EMAIL: CPetion@dhmh.state.md.us

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT
FY 2012 -2013 APPLICATION**

September 2011

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SECTION I – FUNDING AGREEMENTS, CERTIFICATIONS AND ASSURANCES

STATE OF MARYLAND
OFFICE OF THE GOVERNOR



MARTIN O'MALLEY
GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1925
(410) 974-3901
(TOLL FREE) 1-800-811-9336

TTY USERS CALL VIA MD RELAY

July 20, 2011

Grant Management Officers
Division of Grants and Contracts Management
Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Grant Management Officers:

Several federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. In order to expedite the processing of federal grants, on my behalf, I designate the Secretary of Maryland's Department of Health and Mental Hygiene (DHMH), Joshua M. Sharfstein, M.D., to make future assurances, sign applications and agreements, and perform any similar acts relevant to the Department of Health and Mental Hygiene.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin O'Malley".

Governor

cc: Joshua M. Sharfstein, M.D., DHMH



Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET, SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Joshua M. Sharfstein, M.D.
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature

Date

Joshua Sharfstein
8/16/11

Footnotes:

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law-enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), 7, (d), 7, and (f).

For purposes of paragraph 7 regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence; portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

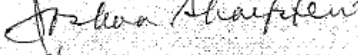

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Joshua M. Sharfstein, M.D.
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature 
Date 

Footnotes:

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

Chief Executive Officer's Funding Agreements/Certifications

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2012

I hereby certify that Maryland agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer support programs, and mental health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Joshua M. Sharfstein, M.D.
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature: *Joshua Sharfstein*

Date: *X 8/16/11*

Footnotes:

--

Approved by OMB No. 0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES	
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352 (See reverse for public burden disclosure.)	
1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award
3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____	
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: _____ _____ Congressional District, if known: _____
6. Federal Department/Agency: _____	7. Federal Program Name/Description: _____ CFDA Number, if applicable: _____
8. Federal Action Number, if known: _____	9. Award Amount, if known: \$ _____
10. a. Name and Address of Lobbying Entity <i>(If individual, last name, first name, MI):</i> _____	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i> _____
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only: _____	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

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Standard Form – LLL (Rev. 7-97)

Approved by OMB No. 0348-0046

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

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SECTION II – BEHAVIORAL HEALTH ASSESSMENT AND PLAN

EXECUTIVE SUMMARY

During FY 2011 and moving into FY 2012, the Mental Hygiene Administration (MHA), the division of the State of Maryland Department of Health and Mental Hygiene (DHMH) that is responsible for overseeing the delivery of public mental health services in the state, was actively involved in numerous activities to refine, enhance, and improve management of the public mental health system (PMHS). MHA places a priority on the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. Access to services is maintained and remains a priority. A consumer and family driven mental health system is preserved and continues to be strengthened through various collaborative efforts. Maryland completes the sixth and final year of the Transformation grant, with many projects sustained and many more having reached a level of momentum that the state is confident will continue beyond the life of the grant.

Under the leadership of the DHMH Secretary Joshua Sharfstein and Deputy Secretary for Behavioral Health and Disabilities, Renata Henry, who oversee the department's Mental Hygiene, Alcohol and Drug Abuse (ADAA) and Developmental Disabilities (DDA) administrations, as well as the Office of Forensic Services, MHA continues efforts that support the mission to foster an integrated process for planning and collaboration to ensure a quality system of care is available to individuals with behavioral health conditions.

As Maryland continues to move toward the implementation of Health Care Reform, several planning activities are underway for integrating the care of individuals with behavioral health disorders. The Department is examining the regulatory changes required of both the mental health and the substance abuse systems into an integrated behavioral health system with a single set of behavioral health regulations. Additionally, the Department is reviewing available data and involving experts and stakeholders so as to develop an inclusive approach for recommending potential financing alternatives. Finally, the Department is exploring the incremental stages necessary for the development and coordination of an integrated Behavioral Health Administration. The Department intends to provide, via conference calls and a designated Web site, opportunities for soliciting input from, and informing the public about, each of the planning and development stages. A special task group has been convened to look at integration of various functions specific to the child, adolescent, and young adult service delivery systems and cross generational promotion and prevention efforts. The charge to this group is to develop a framework for moving towards the optimal system of care and prevention efforts for the State of Maryland.

Maryland is providing separate applications for the FY 2012-2013 Mental Health Block Grant and Substance Abuse Block application; however, there are common areas in which the MHA and the ADAA are providing joint responses. The two administrations plan to explore procedures for the development of a joint behavioral health needs assessment process to further identify behavioral health needs in Maryland.

Public Mental Health System (PMHS) Service Utilization and Expenditures

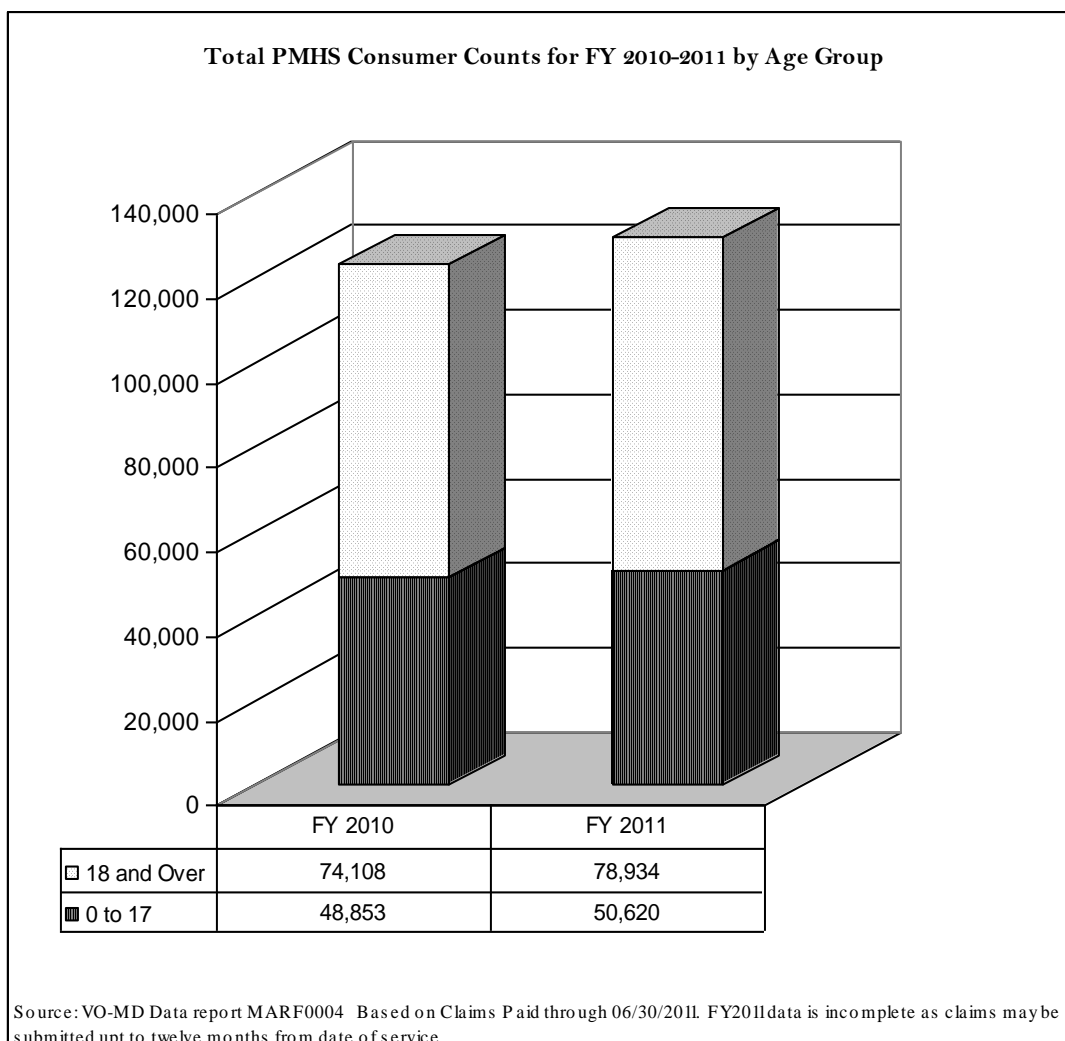
Coverage - The PMHS services both Medicaid recipients and the uninsured population. 13,432 uninsured individuals who meet specific eligibility criteria utilized PMHS services in FY 2010. The total number of individuals served in the fee-for-service PMHS has increased from 94,898 in FY 2007 to 122,067 in FY 2010, a 29 percent increase. This is nearly identical to the 28 percent growth in Medical Assistance eligibility from July 2006 to June 2010. The numbers served increased by 12 percent from FY 2009 to FY 2010, while the comparable increase in all Medical Assistance-eligible individuals grew by 26 percent during this period. Tables on the following pages provide data on consumers served by age group in FY 2010 and 2011. FY 2011 data shows that thus far 129,554 individuals had claims submitted for mental health services through the fee-for-service system. Of the total, 78,934 are adults, and 50,620 are children. This total has increased by 10% during the same time period from FY 2010.

Demographics of Consumers Served in the Fee-For-Service System - The number of children and adolescents aged 0-21 grew over 18 percent while adults 22 and older experienced the largest growth, increasing the numbers served by 39 percent over the same time period between FY 2007-2010.

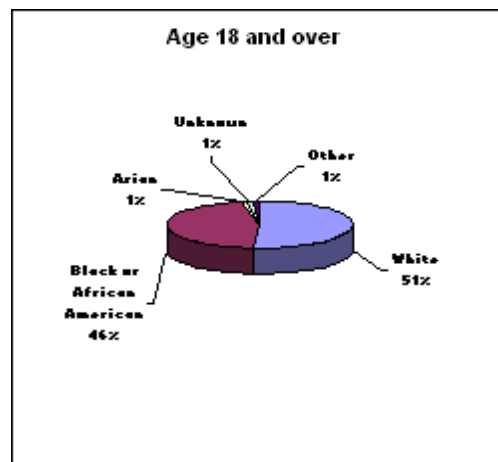
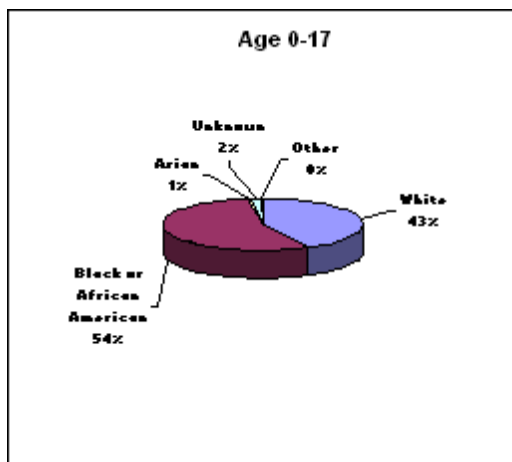
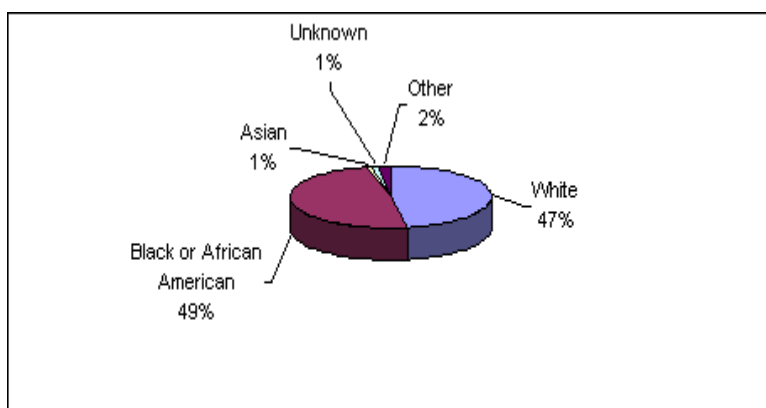
Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2012 State Plan, MHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

The Administrative Services Organization’s Management Information System (ASO MIS) was utilized to produce most of the data. Data for FY 2011 are based on claims paid through June 30, 2011. Since claims can be submitted up to twelve months following the date of service, the data for FY 2011 is still incomplete. Specific diagnoses were used to define SMI. An individual was categorized as Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

Based on claims paid through 6/30/2011, the number of individuals served in the fee-for-service PMHS has increased 5% from FY 2010. The number of child and adolescents increased by 4% while the number of adults served in FY 2011 increased by 7% since FY 2010. Many of these increases result from preparing for implementation or implementing some of the components of the Affordable Care Act, which provided funding allowing states to cover more people with Medicaid. The expansion of Medicaid, especially the extension of Medicaid to the parents of children in Maryland’s Children’s Health Program (MCHP), improved access to health care and services. It is estimated that an additional 25,000 Marylanders will be eligible for Medicaid and 15-17 percent of that population will use PMHS services within the coming fiscal years.ⁱ



Currently, 54 percent of the people served are adults and 46 percent are children. The racial distribution of PMHS population is 49% Black, 47 % White, 1% Asian, 2% other and 1% unknown.

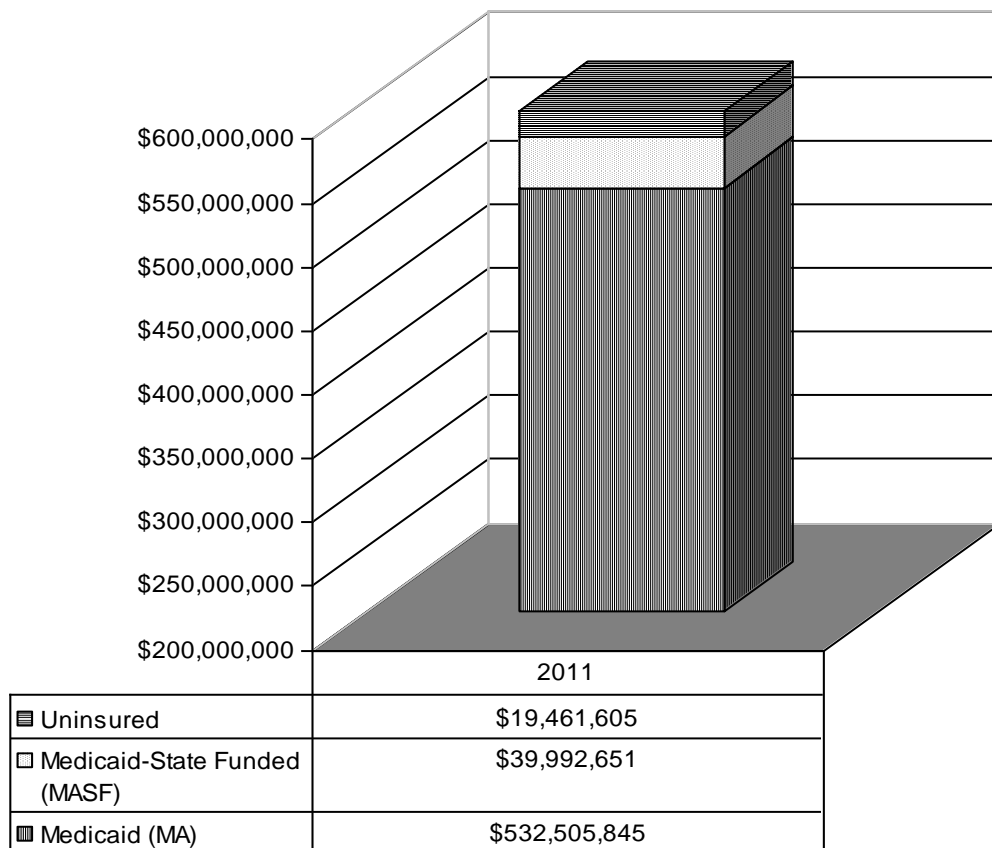


Expenditures and Funding Sources for Marylanders in the PMHS - In FY 2011, 72% of total expenditures were for community-based services (including those in the fee-for-service system and in grants and contracts). In FY 2012, a total of \$1,061,067,808 has been appropriated for the MHA. Of this amount, \$793.4 million (\$681.5 million MA service funds) is for community services, \$259.2 million for State-operated institutions and \$8.3 million for program administration. (Seventy-four point eight percent (74.8%) of the FY 2011 funds are targeted for community services). Several local jurisdictions contribute mental health funding, which is not included in these budget numbers. In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This consists of approximately \$48.1 million in State general funds and \$27.2 million in federal funds. Federal grants include: this block grant, PATH, Shelter Plus Care, Data Infrastructure Grant (DIG), the Mental Health Transformation-State Incentive Grant, the new multi-year System of Care grant for children and other CMHS and CMS grants.

The majority of expenditures in the fee-for-service PMHS are for services reimbursed by MA. Federally matched MA expenditures represent 87-90% of total expenditures. Non-MA expenditures include those for MA-ineligible recipients, non-MA reimbursable services provided to MA recipients, and for services for individuals within state-only MA eligibility categories. In an effort to maximize all MA federally matched funds, MHA continued its practice of converting eligible individuals to PAC, the Primary Adult Care waiver. PAC is a statewide program which covers the fees of Outpatient clinic and Pharmacy services. In FY 2011, the number of Uninsured individuals receiving services in the PMHS decreased by 16% from 2010 while the number of Medicaid eligible individuals receiving services increased by 7% during the same time period. Stricter criteria for uninsured eligibility, PAC expansion and an effort to extend Medicaid benefits to parents of MCHP participants help explain the movement.

(Criterion 5)

Total PMHS Expenditures in FY 2011 by Funding Type

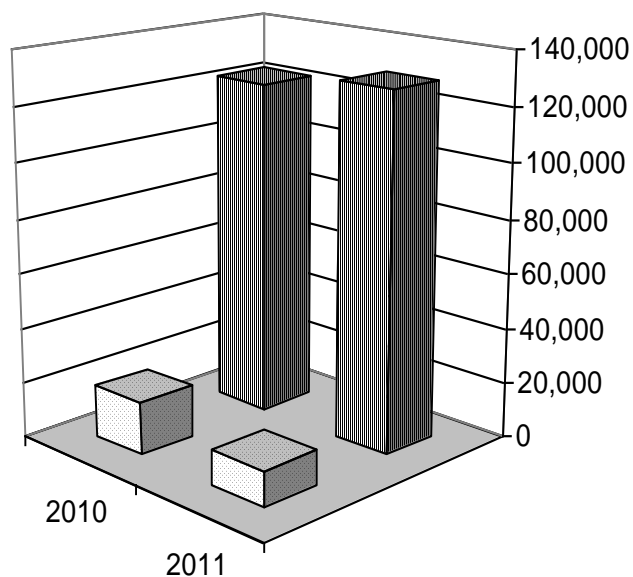


Source VO-MD Data Report MARF0004. Based on Claims paid through 06/30/2011. FY 2011 data is incomplete as claims may be submitted up to twelve months from date of service.

Increasing access to mental health services has been the basis of the redesigned fee-for-service PMHS under the MA 1115 Waiver. Fueled by the growth in MA eligible individuals, increasing numbers have received services, and MHA has had to serve a larger number of individuals more efficiently. In response to budget demands, MHA, in FY 10, instituted stricter service utilization and service eligibility guidelines. Medical necessity criteria for Intensive Outpatient, Partial Hospitalization and Residential Treatment services were revised. Case Management services moved from State funded contract based funding to MA-eligible reimbursement in the Fee-For-Service (FFS) system. Another change effecting PMHS services was the restructuring of the Uninsured Eligibility requirements for authorization of services. As a result of budgetary constraints, MHA has required individuals to be at 200 percent of the federal poverty level or below and satisfy the other eligibility requirements to qualify for uninsured services in the PMHS. The new ASO has been able to closely manage eligibility criteria for the uninsured, resulting in a reduction of the number of uninsured served and the corresponding expenditure.

A significant number of individuals in the fee-for-service PMHS have co-occurring disorders of mental illness and substance abuse. The percentages of adults served have grown steadily over the past four years. In FY 2010, 15% of those served in the PMHS were co-occurring. Working with CSAs, the state Alcohol and Drug Abuse Administration (ADAA), and other stakeholders, MHA is strengthening coordination and integration of services to improve access for consumers with co-occurring disorders. This collaborative approach is designed to ensure clinically sound services for this population and accounted for 28% of the PMHS expenditures within that fiscal year.

Consumers with Co-Occurring Disorders* Served in the PMHS by Fiscal Year



	2010	2011
□ Co-Occurring Population Served	18,733	12,353
■ Total PMHS Population Served	122,961	129,554

Note: * An individual with a diagnosis of substance abuse and mental illness. Source: VO-MD Data Report MARF5120 Based on Claims Paid through 06/30/2011. FY 2011 Data may be incomplete as claims may be submitted up to twelve months from date of service.

FRAMEWORK FOR PLANNING – MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT

Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant Planning Changes:

In an effort to streamline the application and reporting procedures, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance and reporting dates across both block grant programs (Mental Health Services and Substance Abuse Prevention and Treatment). In previous block grant application submissions, the mental health block grant (MHBG), the assessment, current and new developments, and planning activities were addressed under five (5) criteria for adults with serious mental illness (SMI) and children and adolescents with serious emotional disorders (SED). The previous applications required submission of separate Adult and Child Plans.

This year, States are required to develop the behavioral health assessment and plan consistent with the five (5) criteria for the mental health block grant and for the substance abuse block grant, consistent with the seventeen (17) national goals. States must submit their Block Grant applications for 2012 and 2013 based on the new guidance. Although SAMHSA is encouraging States to submit a “unified” application, Maryland is submitting separate block grant applications for mental health and substance abuse, however, throughout the document there are discussions of joint and collaborative efforts of the behavioral health administrations. For this submission the current statutory deadline for the MHBG application submission (September 1) is unchanged, however, the application time period is for a twenty-one month period (10/1/11 – 6/30/13) to align with most States’ fiscal year budget cycle. The subsequent Block Grant applications should be submitted on 4/1/2013 for a two year period (07/01/2013 – 06/30/2015).

Health Care Reform

Maryland's Health Care Reform Coordinating Council (HCRCC):

In response to the enactment of the Patient Protection and Affordable Care Act (PPACA), Maryland Governor Martin O'Malley created the Maryland Health Care Reform Coordinating Council through an Executive Order to advise the administration on policies and procedures to implement the recent and future federal health reform as efficiently and effectively as possible. The Council made policy recommendations and offered implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.

The Council was initially co-chaired by Lt. Governor, Anthony Brown, former DHMH Secretary, John Colmers and was comprised of health leaders across the state. The Council first milestone was the submission of an interim report to the Governor that provides a comprehensive evaluation of the federal legislation and identifies critical decision points that must be considered by the State. The report includes a timeline of legislative and regulatory changes necessary for implementation. The HCRCC had established workgroups, which were open to the public, on six identified areas of focus to address the full scope and complexity of the fundamental aspects of reform. The workgroups focus areas were:

1. Health Insurance Exchange and Insurance Markets;
2. Entry Into Coverage;
3. Outreach and Education;
4. Public Health, Safety Net and Special Populations;
5. Health Care Workforce; and
6. Health Care Delivery System

The HCRCC issued a final report on January 1, 2011. The report set forth a blueprint for well-planned and inclusive implementation of health care reform. The report contained many recommendations including:

- Establishment of a Health Benefit Exchange
- Development of a centralized education and outreach strategy
- Improvement of coordination of behavioral health and somatic services
- Incorporation of strategies to promote access to high quality care for special populations
- Institution of comprehensive workforce development planning
- Achieve reduction and elimination of health disparities through the exploration of financial, performance based incentives and incorporation of other strategies
- Establishment of a Governor's Office of Health Reform

Maryland has already made significant progress implementing these recommendations. In April 2011 Governor O'Malley signed a law that established the Health Benefit Exchange. On May 26, 2011 he appointed a nine member board to oversee the Exchange. DMHH's Secretary will serve as a board member for the Exchange. That same day the Governor signed an executive order to establish the Governor's Office of Health Care Reform. In addition, he extended the term of the HCRCC through 2015. The HCRCC will continue to meet quarterly to monitor progress on implementation of recommendations.

Maryland's Mental Hygiene Administration (MHA) State Mental Health Planning Process:

The MHA's Office of Planning, Evaluation and Training is responsible for the development, implementation and oversight of the State, local and federal planning activities. Each year an extensive plan development process is implemented beginning in January with the submission, to the MHA, of local mental health plans and budgets from the Core Service Agencies (CSAs). The CSA Plan and Budget guidelines are developed through the MHA's Office of Planning to guide the development of local plans in identify priorities, strengths, needs and service gaps of the local public mental health system as well as a description of stakeholder input.

The MHA facilitates an annual plan development meeting in April for stakeholders throughout Maryland. This meeting includes a broad participation of stakeholders including representatives from consumer and family organizations, mental health advocacy organizations, core service agencies (CSAs), local mental health advisory committees, and members of the MHA Management Committee. Additionally, Maryland Advisory/Planning Council (Joint Council) is actively involved in the development of the State Mental Health Plan and the federal Mental Health Block Grant Application. This year, in an effort to enhance our planning process and discussions on health care reform implementation, representatives from the DHMH Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), and Federally Qualified Health Centers (FQHCs) were invited and participated in the planning activities.

Additionally to focus on child, adolescents and youth issues and planning needs, Maryland's family organization developed the Maryland Blue Print for Children's Mental Health. This ongoing strategic planning effort was developed, originally in 2003, and a five year update of the Blueprint was completed last year. The revised vision and mission, as well as the recommendations and suggested strategies themselves, are rooted in the broader public health approach to mental health, including promotion, prevention and early intervention.

Six major themes emerged which became the basis for recommendations and suggested strategies. Within each theme, the recommendations were prioritized, this helps to inform and shape planning and development at State and local levels.

In previous years to foster the implementation of a consumer-driven, recovery and resilience oriented system, MHA followed SAMHSA's lead in adopting the goals and recommendations outlined in the 2003 New Freedom Commission Report: *Achieving the Promise: Transforming Mental Health Care in America*. To continue improvement in the delivery and financing of prevention, treatment and recovery support services, SAMHSA has identified Eight (8) Strategic Initiatives to focus the Agency's efforts. As in FY 2011, MHA organized its FY 2012 plan activities to be in concert with the SAMHSA's Strategic Initiatives. These 8 initiatives are as follows:

- Prevention of Substance Abuse and Mental Illness;
- Trauma and Justice;
- Military Families-Active, Guard, Reserve, and Veteran;
- Recovery Support;
- Health Reform Implementation;
- Health Information Technology;
- Data and Outcomes and Quality; and
- Public Awareness and Support

During the process of updating and drafting the goals, objectives, and strategies for the FY 2012 State Mental Health Plan, MHA staff, advocates, and all involved parties reviewed the goals and recommendations. Many of the key goals in the final report are fundamental concepts in the Mission, Vision, and Values of Maryland's PMHS. All are covered in some aspect of the State Mental Health Plan, in our continuing efforts to promote recovery and resilience, implement evidence-based services, and cultivate a consumer and family driven system in which one's ethnic and cultural background is respected. Maryland takes pride in developing and delivering state-of-the art mental health services and will continue to do so while remaining fiscally and clinically responsible.

In this section, the service system's strengths, needs, and priorities for adults, children and adolescents are identified and analyzed. Review of this section provided both MHA staff and Joint Council members with the opportunity to engage in rich discussions about the strengths and weaknesses of the service system and to identify and reflect upon unmet service needs and gaps within the current system. This process yielded further input into identification of state priorities and strategies included in the current State Mental Health Plan. MHA's FY 2012/2013 priorities include:

- Provision of consistent and seamless access to services and supports for both PMHS consumers, families and providers;
- Continuation of activities to address the needs of individuals with co-occurring disorders.
- Suicide Prevention efforts
- Continuation of MHA's successful approach to the implementation of evidence-based practices and efforts to monitor fidelity;
- Continuation of statewide implementation of Wellness and Recovery Action Plan (WRAP) training to increase wellness and recovery orientation and utilize best practices within the consumer movement;

- Further implementation of the Medicaid Psychiatric Residential Treatment Facility (PRTF) waiver activities to reduce reliance on psychiatric residential treatment by supporting development of community-based, in-home, wraparound services for children and their families;
- Efforts to promote Maryland's implementation of Health Care Reform;
- Continuation of efforts to address training and workforce development issues; and
- Efforts to promote public awareness and safety.

FY 2012/2013 PUBLIC MENTAL HEALTH SYSTEM GOALS

These MHA goals, objectives, and strategies are a result of the collaborative efforts related to the implementation of the federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. These alliances have been strengthened, and new partnerships formed to further build upon the infrastructure, to coordinate care and improve service systems. Mental health transformation efforts and activities have fostered the implementation of increased opportunities for public education; awareness; training of consumer, families, and mental health professionals; support of employment; significant expansion of systems of care for children and families, self-directed care; and affordable housing options. Advancement will be effectively amplified through the support of Web-based technology that increases awareness and linkages to services; promotes wellness, prevention, and diversion activities; and enhances efforts in cultural competency, evidence-based and promising practices. These advancements are infused throughout the MHA State Mental Health Plan for children, adolescents, and adults. Recognizing the current fiscal environment, MHA strategies involve effective and efficient collaborations to identify and support sustainability of transformation gains that promote recovery, resiliency, and health-care reform.

- GOAL I: Increase Public Awareness and Support for Improved Health and Wellness**

- GOAL II: Promote a System of Integrated Care Where Prevention of Substance Abuse and Mental Illness is Common Practice Across the Life Span**

- GOAL III: Work Collaboratively to Reduce the Impact of Violence and Trauma for Individuals with Serious Mental Illness and Other Special Needs**

- GOAL IV: Provide a Coordinated Approach to Increase Employment and Promote Integration of Services and Training to Develop and Sustain an Effective Behavioral Health Workforce**

- GOAL V: Build Partnerships to Increase the Provision of Affordable Housing and Reduce Barriers to Access in Order to Prevent Homelessness for Individuals with Mental Illness**

- GOAL VI: Utilize Data and Health Information Technology to Evaluate, Monitor, and Improve Quality of Public Mental Health System Services and Outcomes**

These goals are linked to the State Priorities on Table 2.

POPULATIONS – CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by *31,000. This average loss is approximately 6,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 5% each year (117,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

Mental Hygiene Administration
Prevalence Estimates for Serious Emotional Disorder (SED) by County
Child and Adolescent Population

County	Under 18 Population	Low Prevalence	High Prevalence
		6%	12%
Allegany	13,277	797	1,593
Anne Arundel	122,494	7,350	14,699
Baltimore County	174,324	10,459	20,919
Calvert	21,833	1,310	2,620
Caroline	8,054	483	966
Carroll	40,617	2,437	4,874
Cecil	24,412	1,465	2,929
Charles	36,962	2,218	4,435
Dorchester	6,764	406	812
Frederick	57,641	3,458	6,917
Garrett	6,398	384	768
Harford	59,315	3,559	7,118
Howard	68,914	4,135	8,270
Kent	3,756	225	451
Montgomery	228,648	13,719	27,438
Prince George's	201,473	12,088	24,177
Queen Anne's	10,838	650	1,301
St. Mary's	26,210	1,573	3,145
Somerset	4,650	279	558
Talbot	7,059	424	847
Washington	32,931	1,976	3,952
Wicomico	21,691	1,301	2,603
Worcester	9,168	550	1,100
Baltimore City	153,154	9,189	18,378
Statewide Total	1,340,583	80,435	160,870

Data Source:

July 1, 2009 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

Comprehensive Community – Based Mental Health Service System (CRITERION 1)

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Case Management
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

MHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services, at least two of which are peer-run. In FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. On September 1, 2009, MHA in collaboration with the CSAs and the ASO implemented and monitored the transition from contracted case management services were moved from State funded contract based services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and licensed clinical professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

Center for Medicare/ Medicaid Services PRTF Waiver - Maryland has been granted a Section 1915(c) Medicaid waiver for home and community-based services for children and youth at the Psychiatric Residential Treatment Facility (PRTF) level of care. Often referred to as the RTC (residential treatment center) Waiver, this effort is based on two high Fidelity Wraparound pilots begun in January 2006 in Baltimore City and Montgomery County. State funding was received through the GOC to expand the program in FY 2007 to an additional two jurisdictions that are able to provide high-fidelity services. At the current time the waiver is open statewide and has allotted 210 slots with a waiting list. A total of approximately 135 youth are currently enrolled. Maryland is one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. Children may remain in the waiver for up to 24 months with an annual review.

A major component of the implementation of the waiver includes the statewide development of Interagency Care Management Entities (CMEs). This effort is strongly integrative of the agency efforts in Maryland. CMEs provide care management, in addition to youth in the PRTF waiver, to {1} youth placed at the group home level by both DHR and DJS; {2} youth under auspices of two SAMHSA funded SOC grants in Baltimore City and on the Eastern Shore of Maryland. The PRFT Demonstration Project will end in September 2012 for new admissions and as a result, the State of Maryland is actively involved in a major sustainability project to sustain and expand the infrastructure created under the PRTF demonstration, the two SAMHSA SOC grants and the state funded care managements slots.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grants - Maryland applied successfully to CMS for the CHIPRA Quality Demonstration grant as the head of a consortium of states, including fellow PRTF demo partner, the State of Georgia, and the State of Wyoming. The grant is the only behavioral health grant among all 10 awarded by CMS, focusing on the implementation, expansion and sustainability of Care Management Entities (CMEs) as described above. As a result, the five year CHIPRA Quality Demonstration becomes an anchor in the sustainability planning for CME and System of Care efforts started up under the 1915(c) and SAMHSA SOC grants.

In brief, the CHIPRA grant will support a number of projects toward sustainability over the course of the two years covered by this block grant application: These include the following:

- Finance project- Development of a financial sustainability plan, including the development of a Section 1915(i) state plan amendment
- Psychopharmacological Project--Developing State of the art mechanisms to assure appropriate uses of medications with children and adolescents in the Medicaid program.
- Somatic health—Strengthen CMEs to expand their focus to include coordination of somatic care such as access to well child visit, EPSDT, dental, smoking cessation , obesity, poor nutrition, and health care consumer skills, and other critical health care coordination issues as they arise.

- Peer Support--Refining and strengthening Maryland's approach to family to family peer support and developing appropriate reimbursement mechanisms to support peer support as a Medicaid service. Possible examination of the difficult area of developing youth peer support services and developing infrastructure to support this service.

Public and Academic Partnerships - A major outgrowth of the original Blue Print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Innovations Institute, as it is called is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute in the past include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence-based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare. Current major projects in which the Innovations Institute is a major partner include the following, some of which have been described in detail above:

- PRTF Demonstration Project—see above
- CMS funded CHIPRA Quality Demonstration—see above
- “MD CARES & Rural CARES” – see discussion below.

The Maryland Child and Adolescent Mental Health Institute - A major outgrowth of the original Blue Print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Institute is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence-based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare.

- In addition to the above, the Maryland Child and Adolescent Innovations Institute, of the University of Maryland Division of Child and Adolescent Psychiatry, was initiated in 2005 to assist the State of Maryland, the Children's Cabinet, the Governor's Office for Children (GOC), Maryland jurisdictions, and the state's child-serving agencies to support efforts in improving access, services and outcomes for families of children with intensive needs. Innovations Institute seeks to assist the state of Maryland and local jurisdictions with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. The Innovations Institute is funded by the Governor's Office for Children (GOC).
- The Johns Hopkins University School of Medicine offers a broad range of research, educational, and clinical resources. The Department of Psychiatry and Behavioral Sciences has over 200 full-time faculty members and an extensive program of research supported by multiple funding sources, including over \$38 million annually in National Institutes of Health (NIH) grants. The Division of Child and Adolescent Psychiatry consists of 40 full-time faculty members who are located in diverse clinical settings. The faculty are committed to training clinical researchers in the following areas of interventions research with children and adolescents: 1) efficacy studies evaluating new or available but un-validated medication and/or psychosocial treatments; 2) effectiveness studies of empirically supported treatments applied in diverse populations and settings; 3) safety and adverse effects of psychotropic medications, particularly during long-term treatment; and 4) methodological approaches and techniques that inform the specificity of treatment to identify which treatments work best for which individuals. The research environment in the Division of Child and Adolescent Psychiatry is very collaborative in nature, offering many opportunities and resources.

SERVICES FOR PERSONS AT RISK OF HAVING SUBSTANCE USE AND/OR MENTAL HEALTH DISORDERS

Details of the more specific interagency initiatives are presented below. The service sectors (identified in Criterion 3 of the previous Block Grant guidance specifically for integration efforts with mental health services) include: {1} social services; {2} education (including, but not limited to, special education); {3} juvenile justice; and {4} substance abuse services. These are discussed in the order they appear in the federal statute.

Mental Hygiene Administration's Office of Child and Adolescent Services (OCAS) is responsible for planning, monitoring for program compliance and building partnerships to ensure the delivery of mental health services to children and their families within the public mental health system (PMHS). The Office works closely with other child-serving agencies and the core service agencies to improve access and coordination of care for the child and adolescent population.

The Office, with its partners and stakeholders, provides leadership, expertise and guidance to promote wellness, prevention and resiliency in all child and adolescent mental health. These efforts range from a few universal prevention programs to the most intense levels of care in every jurisdiction. Maryland continues to make progress in growing its System of Care, imbued with core values of being child-centered, family and youth driven, community-based and culturally and linguistically competent.

The Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children Youth and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation. The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes Deputy Secretaries and other key members from the same agencies as the Cabinet. The director of MHA's Child and Adolescent Services is a major participant in the CCRT's work, providing staff support to the Secretary of Health and Mental Hygiene in his role on the Children's Cabinet and representing DHMH on CCRT. As a result, mental health is well represented with major input into all policy decisions and programs. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe, and healthy environment for children and families. The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

Clearly, Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children’s Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland’s commitment to youth and family involvement.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, and formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state’s child welfare system. MHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PMHS as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation’s Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading an effort to bolster new foster family homes so that children live in closer proximity to their family members and their communities. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.
- **“Other DHR”** - Other DHR social services, outside of child welfare, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). Child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education and will be discussed in conjunction with early childhood education. For those in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.
- **“MD CARES & Rural CARES”** – Funded through two SAMHSA systems of care grants, MD CARES and Rural CARES projects are key child welfare collaborations in major geographic and population centers of the State. In Maryland there are approximately 10,100 children in foster care, of which approximately 6,100 are from Baltimore City. Grant funds will be used to expand and support “wraparound” services to foster children in their communities.

- **Crisis Stabilization and Response** - A related joint venture with DHR, first funded in FY 2009, is a mental health crisis response and stabilization system designed to help respond to children in kinship care, in-home and foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalization do not result in the disruption of the child's residential placement. Nine service provision areas covering 16 counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel Counties; and Baltimore City. However, further expansion of this project has unfortunately been curtailed due to budget limitations.

Educational services (including those provided by local schools and the Individuals with Disabilities Education Act (IDEA) – School Based Mental Health - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services

Early Childhood Mental Health - The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by IDEA, is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

Juvenile Services – The Mental Hygiene Administration (MHA) consults and collaborates with the Department of Juvenile Services (DJS) to coordinate mental health services within their juvenile detention centers. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis. In FY 2010, the Director of Child and Adolescent Services began a Psychopharmacology Learning Collaborative consisting of psychiatrists who provide services to youth in the juvenile justice system. The focus of the Collaborative is to examine the use and administration of psychotropic medication to youth in custody.

Substance Abuse Services Including Co-occurring Disorders - In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses.

Maryland is poised to move forward in developing an integrated system of care for youth with mental health and substance abuse issues by establishing of a 'virtual' Office of Child & Adolescent Behavioral Health that will build upon the respective strengths of both ADAA and MHA, from the perspective of those organizations, respective local counterparts, and staff. As depicted in the below diagram, the goal of the integrated system would be to coordinate the administrative structures, financing, regulations, and service delivery systems within each Administration. This structure will also allow for coordinated behavioral health workforce development. The Office of Child & Adolescent Behavioral Health will support more effective access to services and improved outcomes for youth and youth adults with behavioral health needs and their families.

The Secretary of the Department of Health and Mental Hygiene (DHMH) has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this position, a state-level leadership team has been convened to provide leadership toward enhanced service coordination across systems.

Health and Mental Health Services - Our efforts to improve coordination of somatic and behavioral health care under the CHIPRA Demonstration grant have been described in a prior section. In addition, because DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is DHMH's Special Needs Advisory Committee. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts are also implemented at the county level to promote the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the State's involvement in the SAMHSA National Policy Academy.

Resources for Military Families - The Maryland Coalition of Families (MCF) for Children's Mental Health, a statewide child and family advocacy group, also recognizes the needs of children whose parents are serving in the military. April was the Month of the Military Child, with a slogan titled "Kids Serve Too"! Children must cope with frequent moves, new schools and loss of friends. They also experience separation from one or both parents as well as additional challenges as their returning parent may arrive home with physical or emotional scars from deployment. MCF recently received a grant from the federal Center for Mental Health Services and hired a Military Family Navigator for families at Fort Meade who have a child or children with special needs. Fort Meade is a designated Compassionate Deployment Site where military families are stationed specifically because of a child or dependent with special needs. This is because of Maryland's system of care and the availability and accessibility of services within the State. The Military Family Navigator will assist military families to access resources on their base or in the community.ⁱⁱ

TARGETED SERVICES

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using this System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level.

DHR gathers and reports information only on people and families who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

Services for Runaway and Homeless Youth - The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed.

Services for Children in Homeless Families - MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

The Chrysalis House Healthy Start (CHHS) Program administered by MHA serves children. Thirty six (36) infants have been born to 33 women at CHHS, including one set of twins. Of the 33 women, 23 of them were homeless at the time of admission. Services that support the children

within the families include prenatal care, nursing care and health education groups for the mothers, parenting classes provided through Family Tree, nurturing and bonding, onsite daycare, and case management services. Eight of the women who were homeless moved into Shelter Plus Care Housing.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

MHA's Shelter Plus Care Housing Program housed 312 children, within the 189 family households. In addition to the housing the families received an array of supportive services through state, local, and private agencies. Services included mental health treatment, case management, alcohol and substance abuse services, health care, legal services, child care, etc.

Rural - Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2008 - Maryland Vital Statistics Annual Report 2008. While the Mental Hygiene Administration will continue to utilize the foregoing definition of rural counties for purposes of this Mental Health Block Grant Application, the Office of Health Policy and Planning of the Maryland Department of Health and Mental Hygiene published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis. "The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources. Compared with the state overall, Maryland's rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural populations tend to be older and exhibit poorer health behaviors such as higher rates of smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities."

The DHMH Office of Rural Health convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue.

Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities. **(Criterion 4)**

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence however; were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
 - Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or

- Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
 - Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

Mental Hygiene Administration
Prevalence Estimates for Serious Mental Illness (SMI) by County
Adult Population

County	Over 18 Population	Prevalence 5.4%
Allegany	58,961	3,184
Anne Arundel	390,296	21,076
Baltimore County	611,294	33,010
Calvert	66,865	3,611
Caroline	25,084	1,355
Carroll	128,736	6,952
Cecil	75,514	4,078
Charles	103,802	5,605
Dorchester	25,234	1,363
Frederick	168,080	9,076
Garrett	23,300	1,258
Harford	181,036	9,776
Howard	206,081	11,128
Kent	16,395	885
Montgomery	722,032	38,990
Prince George's	619,379	33,446
Queen Anne's	36,253	1,958
St. Mary's	75,368	4,070
Somerset	21,469	1,159
Talbot	29,156	1,574
Washington	112,453	6,072
Wicomico	72,355	3,907
Worcester	40,106	2,166
Baltimore City	483,765	26,123
Statewide Total	4,293,014	231,823

Data Source:

July 1, 2009 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

Comprehensive Community – Based Mental Health Service System (CRITERION 1)

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Case Management
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

MHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer-run. In FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. On September 1, 2009, MHA in collaboration with the CSAs and the ASO implemented and monitored the transition from contracted case management services were moved from State funded contract based services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and licensed clinical professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

MHA's Offices of Adult Services, Consumer Affairs, Special Needs Population and Forensic Services ensures that a comprehensive system of mental health services and supports are available and accessible for adults from age 18 throughout the life-span. These offices oversee the statewide planning, design, development, implementation, administration and monitoring of community-based mental health programs and services for adults, transition-age youth, and

older adults. Additionally services are offered to individuals who are homeless, individuals who are deaf or hard of hearing, individuals with mental illness and/or substance abuse disorders and trauma-related effects, as well as individuals with mental illnesses who are court –involved. In addition, these offices formulate policy, protocols, regulations, and practice guidelines to support systems transformation for improved consumer outcomes; promotes evidence-based, consumer-directed and recovery-oriented rehabilitation, treatment and supports that have demonstrated effectiveness and are responsive to consumer needs and preferences.

Housing – MHA’s promotion of supported housing and consumer choice in housing is another system strength. The policies and programs developed by MHA reflect this commitment. Rates in the fee-for-service system help to support individuals’ abilities to live in their own homes. Priority for community bond (capital) financing is given to the development of affordable housing projects. MHA’s strong interagency collaboration with the Department of Housing and Community Development (DHCD) and the Department of Disabilities (MDOD) has resulted in increased housing options for consumers of behavioral health services.

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the recovery of persons with serious mental illnesses (SMI). Toward this end, MHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized federal and state government-supported housing opportunities as well as local county resources and private foundations. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

To assure that consumers of mental health services have a continuum of housing and other residential options, MHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing and rental subsidies along with accompanying support services as needed and requested by the consumer. Providers of residential rehabilitation services with CSA support have submitted applications for HUD 811 that comes with designated Flexible Housing Choice Vouchers. However, due to changes in the federal budget priorities and the increase cost of all housing, access to new housing vouchers for individuals with disabilities has been limited. Currently, MHA is collaborating with local public housing authorities (PHAs) and other organizations to implement the Federal Non-Elderly Persons with Disabilities NOFA that provided new vouchers for persons with disabilities in Howard, Baltimore County, Carroll, Montgomery, DHCD jurisdictions, and Baltimore City.

MHA continues its housing initiative with support and technical assistance from the Technical Assistance Collaborative (TAC). In addition to TAC, MHA has collaborated with DHMH’s Office of Capital Planning, Budgeting and Engineering Services, the Maryland Departments of Disabilities and Housing and Community Development (DCHD), local housing authorities, and community providers to examine housing options for persons with disabilities specifically those with SMI and those with developmental disability. Accomplishments include:

- Recent award of \$1 million from the Weinberg Foundation. Under a Memorandum of Understanding, the Weinberg Foundation and the above mentioned state agencies will work together to finance affordable, quality, independent, integrated housing opportunities for very low income persons with disabilities who meet certain eligibility criteria. The Weinberg units will house non-elderly, disabled households at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. Work with local public housing authorities will continue to help secure access to and stability in housing for consumers.
- Conducted an assessment of current state housing programs and funding resources. A central purpose was to determine use of existing funding; identify new and reconfigured funding sources to expand affordable, safe, and integrated housing opportunities; and address the important nexus between community mental health and subsidized housing programs. This work has given particular attention to promotion of recovery and self-sufficiency. The Technical Assistance Collaborative has provided key technical assistance in this collaborative effort.
- Increased the number of individuals who obtain affordable housing each year by using funds from DCHD and the federal Department of Housing and Urban Development. In addition, the Maryland General Assembly approved a total of \$6,167,000 to serve individuals with mental health needs, by providing new housing options under the Community Bond Program. In previous years, the Community Bond program provided funding toward housing for more than 525 individuals.
- Received \$3,897,846 from the Department of Housing and Urban Development's Rental Assistance Program for Non-Elderly Persons with Disabilities Program for a total of 372 Category 1 and Category 2 vouchers.
- Received \$1,586,369 from the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (VASH) program. VASH combines Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by the Veterans Affairs (VA) at its medical centers and in the community. A total of 140 vouchers are available with this funding.

MHA continues to fund Main Street Housing, Inc., a consumer-operated project, whose mission is to enable consumers with limited income to live in the least restrictive setting. Main Street Housing, a subsidiary non-profit corporation of On Our Own of Maryland, is dedicated to providing safe and affordable housing to persons with psychiatric disabilities. Main Street Housing is now designated as a Community Housing Development Organization (CHDO). Under the MHT-SIG grant, they developed a database system to track tenant outcomes. The system will focus on understanding the relationship between stable, permanent housing and the stability of the tenants. Also staff from property management can better pinpoint when a tenant may need a referral to supportive services before housing options are in jeopardy. MSH has been using the database to log rent, enter inspection reports, and enter maintenance tasks since its inception. This database uniquely brings MSH to a state of the art capacity regarding the organization's ability to better serve their tenants. MSH is in the process of working out a schedule of what their next steps will be for this program, as it is important that they look to the program to evaluate people and not properties.

MHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with SMI in need of intensive services and supports to eventually integrate into the community. Expansion of RRP beds in the last several years has been targeted to specific initiatives. Currently there are 2482 RRP beds in the system. Based on claims paid through 6/30/2011, a total of 3939 individuals with SMI received RRP services and a total of 4093 adults had claims submitted for RRP services. MHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including PRPs, case management and other supports to enable them to live in housing of their choice. In this model, consumer housing is not dependent on the receipt of services. Persons with SMI also access housing through licensed assisted living providers located throughout the state.

In July 2009 MHA joined a cooperative effort with DDA and ADAA to develop services for individuals with behavioral health issues and developmental disabilities who are currently in state hospitals and will be transitioned to more appropriate care settings. The Transitions Program at Potomac Center provides a therapeutic environment in which men and women with mental illness and intellectual disabilities, and at times substance abuse concerns, receive active treatment appropriate for their strengths and needs as well as goals and wishes. The therapeutic environment provides treatment for the mental illness and substance abuse issues while assisting each person served to pursue self direction with regard to their life skills, choice of residence and vocational pursuits. The program's ultimate focus is to help each person return to the community of their choice as soon as possible.

Olmstead Related Activities - The Maryland Department of Disabilities develops a cross-disability plan that addresses housing, employment, transportation and consumer rights. The 2009 Plan continues to provide direction for Olmstead – related activities for the State and calls upon units of State government to cooperatively engage in a variety of activities to promote consumer self-direction and consumer-centered services. The Maryland Department of Disabilities has become increasingly involved in the housing issues for persons of all disabilities, in order to streamline cross-disability efforts and maximize State and federal resources.

Additionally, MHA expanded residential services in Washington County to serve individuals currently hospitalized in the Finan Center. MHA continues to work with Frederick County to monitor the program assisting transition age youth with mental illness and developmental disabilities, who are aging out of residential treatment centers, in State hospitals, or returning from out-of-state placements. This project is being implemented in partnership with the Developmental Disabilities Administration.

MHA continues to fund and partner with Montgomery County CSA regarding an independent living project using ten Moderately Priced Dwelling Units (MDPUs) for ten individuals from state hospitals. Finally, MHA will continue utilizing the federal Olmstead planning grant to contract with On Our Own of Maryland for peer support counselors in State hospitals who work with consumers, supporting their transition to the community. As noted earlier, a total of 106 consumers in state facilities were seen by Peer Support Specialists (PSS). PSS staff also provided assistance to Wellness and Recovery Centers and to the CSAs.

Evidence-Based Practices (EBPs) – The mental health field has benefited from a substantial body of research about practices that can improve the lives of many people who experience mental illness. The Mental Health Systems Improvement Collaborative (MHSIC) was created in 2001 as a joint venture between the Mental Hygiene Administration (MHA) and the University of Maryland, Baltimore (UMB). MHSIC is located in the Division of Services Research, which is a unit of the School of Medicine's Department of Psychiatry. MHSIC is made up of the Mental Health Services Training Center, the Evidence-Based Practice Center (EBPC) and the Systems Evaluation Center (SEC). Through the block grant, MHA funds the EBPC and the SEC at the MHSIC. These three Centers work in partnership with MHA to foster and support the continued development of the Public Mental Health System (PMHS). The combination of Centers provides an opportunity to initiate changes in system management, policy development, and service delivery while assessing and analyzing system performance.

The EBPC is in the ninth year of active implementation of Evidence-Based Practices (EBPs) for adults. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Additionally a Co-Occurring Disorders Specialist is working to move the system towards Dual Diagnosis Capability, and is also monitoring the activities of two programs implementing Integrated Dual Disorders Treatment. Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by MHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score a minimum of 4.0 on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate.

MHA's relationship with the state Division of Rehabilitation Services (DORS) is another example of Maryland's collaborative strengths and commitment to supported employment. Outstanding integration between MHA and DORS at the state level and among CSAs, programs, and local DORS offices, has been recognized as exceptional by national leaders in implementation of evidence-based practices.

In July 2011, Maryland began piloting the newly expanded Assertive Community Treatment (ACT) assessment tool developed through initial funding by the Washington State Mental Health Division, Department of Social and Health Services, Health and Recovery Administration. Named the *Tool for Measurement of Assertive Community Treatment* (TMACT), this instrument will eventually replace the current mechanism for gauging adherence to the established ACT model. The *Dartmouth Assertive Community Treatment Scale* (DACTS) has been the assessment tool used to monitor Maryland ACT services since 2002, and to which reimbursement rates are tied.

The TMACT, based on the DACTS, expands the assessment to include qualitative information along with team structuring. TMACT measures six subscales: (1) Operations and Structure, (3) Specialist Team, (4) Core Practices, (5) Evidence-Based Practices and (6) Person Centered Planning and Practices, integrating team structure, staffing and practices. Monitoring of these subscales will improve ACT service delivery. Currently piloted in several states, TMACT is still undergoing revisions and refinements. This tool will be used for quality improvement purposes

until the research is completed. Fidelity scoring for ACT teams will rely solely on the DACTS until TMACT research is completed.

In August 2010, Maryland Mental Hygiene Administration (MHA) partnered with the National Alliance on Mental Illness of Maryland (NAMI MD), was selected along with Kentucky and Washington, D.C., to join seven other states already participating in the Johnson & Johnson – Dartmouth College Community Mental Health Program, Family Advocacy Team Project. MHA's Director of Vocational Services and Evidence Based-Practices, MHA's Director of Consumer Affairs, EBP Trainer and Consultant, NAMI's Family-to-Family State Coordinator, and three additional, active NAMI members representing four large NAMI MD affiliates, traveled to Dartmouth College for an intensive two-day training on supported employment. A small stipend of \$4,000 was provided to NAMI MD to facilitate expanding SE information to families. In each of the remaining two years of the project, NAMI MD will receive \$1,900 to offset incurred expenses related to providing educational SE information to families.

The purpose of the project is to increase awareness of Evidence-Based Practice (EBP) Supported Employment (SE) among family members of persons with serious and persistent mental illness. Armed with information about the positive impact of employment and the incentives in place to protect benefit loss, families will be better prepared to provide necessary supports when their loved ones move into the work force.

This collaboration between MHA and NAMI supports dissemination of SE information to families and consumers. The MHA and NAMI Family Advocacy Team has provided two full-day workshops for providers, consumers, and family members on SSI/SSDI Benefits Counseling, a 30-minute teleconference on the core principles of SE (now posted on the NAMI MD Web site), as well as multiple presentations to families, consumers and providers on the valuable role employment has in recovery from mental illness. Families and consumers are introduced to SE core principles, locations of EBP SE programs and how to access SE services. The Family Advocacy Team is reaching out to SE programs and linking them with NAMI Affiliates, as a resource for NAMI Informational Meetings. The J&J-DC Family Advocacy Team Project supports families and consumers as they advocate for high fidelity EBP SE services in communities lacking SE programs.

SERVICES FOR PERSONS AT RISK OF HAVING SUBSTANCE USE AND/OR MENTAL HEALTH DISORDERS:

Services for Individuals with Mental Illness and Substance Use - Over the past 18 months, the Mental Hygiene Administration (MHA) has worked toward the implementation of a work plan designed to increase the number of programs that are dual diagnosis capable (DDC). Six county jurisdictions which have chosen to adopt the implementation of the Comprehensive, Continuous Integrated System of Care model (CCISC) are in various stages of development. Assertive Community Treatment (ACT) teams are receiving training on interacting with substance abuse to improve the Dual Diagnosis Capability of each of the 10 ACT teams, on an individualized basis.

MHA, in collaboration with the Alcohol and Drug Abuse (ADAA) and the Developmental Disabilities Administrations (DDA), co-sponsors a DHMH Supervisors' Academy. This Academy began in the spring of 2010, and ended April 2011. Participants are from all three administrations. Utilizing a Training of Trainers format, participants are learning the training models from a curriculum developed by Southern Maine, and adapted to include developmental disabilities and traumatic brain injury, as well as Maryland-specific information. MHA's Office of Special Needs Populations provides training through OETAS and the DHMH's Supervisor's Academy on trauma.

MHA has also sponsored regional workshops on screening and assessment for substance abuse, to encourage integrated treatment. These trainings are also open to the other two administrations mentioned above. In the coming year, each Core Service Agency (CSA) will have individual consultation to engage in a discussion about the best way to achieve dual diagnosis capability for their providers. The discussion will include how to ensure integrated care of the co-occurring population.

An important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to provide substance abuse and mental health services for people who are homeless. The grant enables communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (in this plan co-occurring refers to individuals who have mental illness and substance abuse disorders). In Maryland, People Encouraging People, long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual-diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems.

MHA also provides \$440,000 in State general funds for the Trauma, Addictions, Mental Health, and Recovery (T.A.M.A.R.) Project which provides treatment for incarcerated men and women who have histories of trauma and have been diagnosed with a mental illness and/or co-occurring substance abuse disorder. The project is available in eight county detention centers: Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Prince George's, Washington Counties; and at Springfield Hospital Center. In FY 2011, TAMAR is expected to serve nearly 600 individuals with a combination of services that include individual and group counseling, grief counseling, and case management. FY 2012 welcomes the expansion of TAMAR to nine jurisdictions by adding Harford County.

MHA's Office of Special Needs Populations collaborates with ADAA and/or local health departments to address the needs of those with co-occurring disorders who have histories of trauma, are homeless, deaf or hard of hearing, or have criminal justice involvement. The Maryland Community Criminal Justice Treatment Program (MCCJTP) mental health staff work in partnership with the substance abuse staff from the local health departments to coordinate services for those with mental illness and substance abuse disorders. MHA also co-leads the Maryland Correctional Administrators Association (MCAA) mental health and substance abuse subcommittee to address the needs of those incarcerated in local detention centers. ADAA participates on the MCAA subcommittee. In MHA's TAMAR Programs, 88% of the program's participants have co-occurring disorders. In the Chrysalis House Healthy Start Program 64%, have a co-occurring disorder and over 50% of those in PATH and the Shelter Plus Care Program have co-occurring disorders.

Services for Women who are Pregnant and Have A Substance Use and/or Mental Health

Disorder - The majority of the women with co-occurring disorders in the criminal justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing a program for eligible pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW).

The Chrysalis House Healthy Start Program, which replaced the TAMAR's Children Program, is a collaborative effort with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility for pregnant and post-partum women and their babies. Pregnant women are referred by the court, the State's Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team. After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment; which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services (which include involvement from the Healthy Start and Family

Tree Programs) housing; after-hours residential support; health education; and other support services.

Between July 2007 and June 2011, there have been a total of 69 separate admissions (58 women – a number have had more than one admission) to the program and over 20 healthy babies have been born during this period. The majority of women are known to have both mental health and substance abuse issues and a significant history of trauma. Just fewer than 80% were admitted directly to the program from local detention centers, and a quarter of the women were previously incarcerated at Baltimore City Detention Center.

Evaluations undertaken have reported significant improvements in mental health, overall health, and day to day functioning and significant reductions in criminal behavior. Eight of the women have subsequently moved into Shelter Plus Care housing programs.

Impact of Returning Veterans on the Mental Health System and Available Services –

In FY 2008, Maryland's Commitment to Veterans (MCV) was a three-year collaborative partnership among the Department of Health and Mental Hygiene (DHMH), the U.S. Department of Veterans Affairs (USVA), the Maryland Department of Veterans Affairs, and the Maryland Defense Force. The project, funded by the State of Maryland, was designed to help combat veterans and their families obtain the behavioral health services they need upon the veteran's return from conflict. The primary objective was helping veterans of foreign wars and of the Iraq and Afghanistan conflicts link to eligible services within the U.S. Department of Veteran Affairs. Maryland was the first state in the country to add a comprehensive veterans' portal to the state's Network of Care Web site as an additional resource to obtaining access to services. In collaboration with DHMH and through Regional Resource Coordinators, efforts were implemented to improve initial access to behavioral health care services provided through the United States Department of Veterans Affairs or the Public Mental Health System (PMHS) to expedite timely referrals for veterans returning from Iraq and Afghanistan. Activities included:

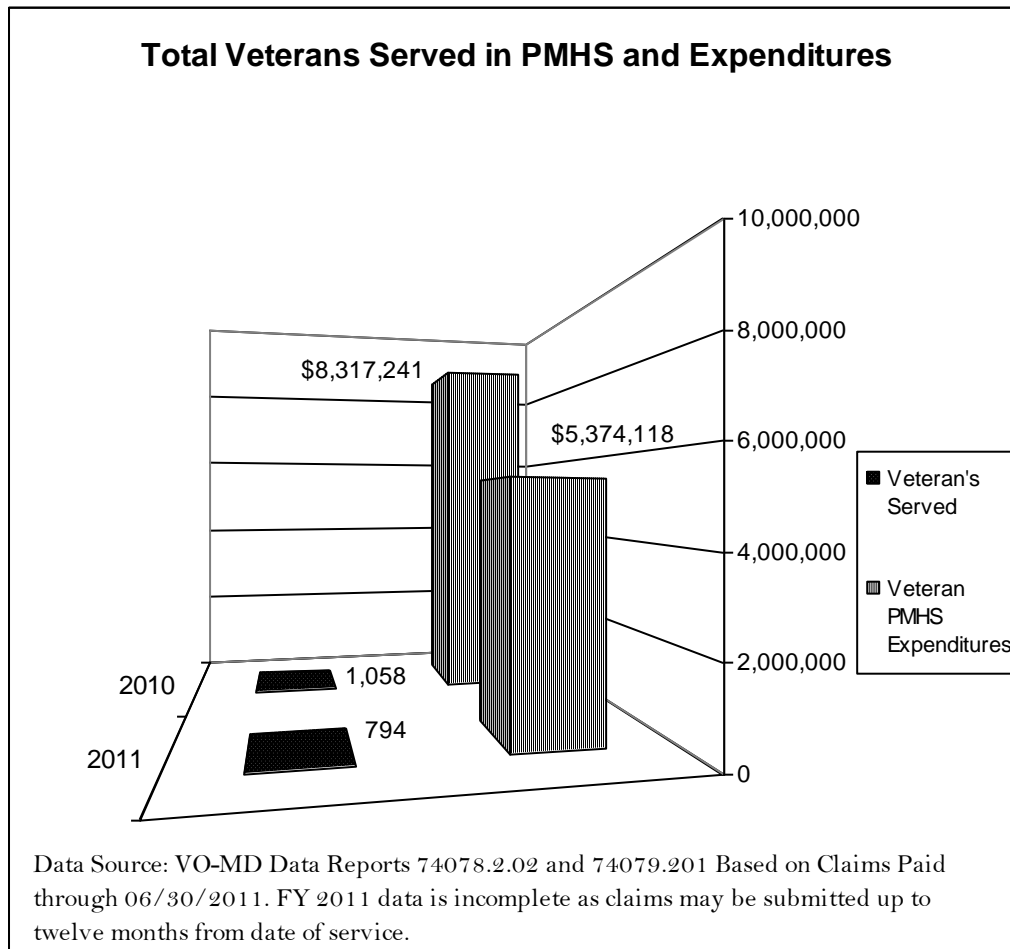
- Assistance provided to access crisis and emergency services, mental health and substance abuse services, information given on Veterans' Administration (VA) benefits and community resources
- Data on Veterans Initiative monitored and reported
- Network of Care link to Veterans' information maintained and utilization monitored as needed
- MHA participation on the Veterans' Behavioral Health Advisory Board

Data has identified that in FY 2010, 1,058 veterans have been served in the PMHS and in FY 2011, 794. MCV has found that veterans/active duty service member callers first request assistance with benefits, housing and employment issues. Once MHA began working with them on these issues, they almost always state a need or desire for mental health treatment, "someone to talk to". 65% of veterans remain un-enrolled in the US Veterans Affairs. This percentage is the same for Maryland and nationally.

The Veterans Behavioral Health Advisory Board, chaired by Lt. Governor Anthony Brown and co-chaired by the Secretaries of the Maryland Department of Health and Mental Hygiene (DHMH) and the Department of Veterans Affairs (Md.VA), held two administrative meetings and three regional meetings around the state in Southern Maryland, Western Maryland, and on the Eastern Shore. Each meeting included a panel of local representatives from USVA service centers, a veteran service organization, a veteran and/or family member, and/or a service provider. The panels provided insights to the challenges (a) faced by veterans and their families in accessing services and (b) encountered by providers in providing services to veterans. Some of the challenges include transportation. Public transportation is available in urban areas; however, is limited or non-existent in rural or suburban areas. Better coordination of care is needed between USVA and state services as well better outreach and education.

Maryland Commitment to Veterans accomplishments:

- While the Advisory Board conducted its work, efforts were underway to begin to address the gaps in service. Pursuant to Section 13-2702, the Maryland Commitment to Veterans (MCV) program was created to provide service coordination for Operation Iraqi Freedom or Operation Enduring Freedom (OIF/OEF) veterans and provide information to veterans about behavioral health services and resources. With the passage of House Bill 1475 during the 2009 Legislative Session, the MCV program was expanded to serve veterans from all foreign wars as of October 1, 2009.
- MCV's Regional Resource Coordinators (RRCs) began work on August 18, 2008 and are assigned to cover Maryland's western, southern, central and eastern shore regions. The RRCs actively link eligible OIF and OEF veterans to appropriate behavioral health services provided through the USVA or, if timely access to USVA services is not available, to the public mental health system. The call center also has the capacity to do a live transfer to a crisis hotline if necessary.
- To expedite the referral process to federal services, the DHMH and the USVA finalized a Memorandum of Understanding (MOU) in November 2008 outlining the specifics of each program and delineating the process by which referrals will be handled and how services will be provided. On April 27, 2009, Lt. Governor Anthony Brown announced the launch of the Maryland's Commitment to Veterans website featuring user-friendly navigation, up-to-date features and comprehensive information to serve veterans and their loved ones (www.veterans.maryland.gov).
- The USVA VISN 5, which serves the Central Maryland and Eastern Shore regions, was awarded a grant of \$300,000 in September 2009 to develop additional services on the Eastern Shore. The DHMH and USVA are working collaboratively to maximize these funds to enhance services.



Maryland's HIV Prevention and Intravenous Drug Users - The Maryland Community Planning Group (CPG) develops a set of statewide HIV prevention priorities. Representatives from the Maryland Department of Health and Mental Hygiene (DHMH) Alcohol and Drug Abuse and Mental Hygiene Administrations (ADAA and MHA) serve on the CPG. The CPG's priorities are based on evidence including HIV and AIDS statistics, injection drug use trends, behavioral science, and input from affected communities. The CPG's Plan is used by the DHMH Infectious Disease and Environmental Health Administration (IDEHA) in writing the state's application to the CDC for funding to support HIV prevention programs across the state.

Injection drug use ranks among the top five priorities for the CPG. The CPG approved Maryland's 2010-2011 HIV prevention priorities were ranked as follows:

1. HIV Positive Persons
2. Men who have Sex with Men (72% African American)*
3. Heterosexual (83% African American)*
4. Injection Drug Users (IDU) (86% African American)*
5. Deaf and Transgender persons

*These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized. Within each risk group, African Americans are emphasized, given the disproportionate impact of HIV in this group. When aggregated, the HIV prevention projects targeting each risk group serve mostly African Americans. Individual projects do not have to meet these racial goals (e.g., when client level data from all injection drug users (IDU) projects are added together, 86% of the IDU served should be African American IDU).

TARGETED SERVICES

Services for Individuals in the Criminal Justice System - The Maryland Community Criminal Justice Treatment Program (MCCJTP), with total annual state funds of \$1.9 million, supports specific programs targeted at adults 18 years of age and older with SMI in detention centers. The development and delivery of care extended to these individuals is rooted in two key principles: 1) a continuum of care should be created by providing a variety of services by mental health professionals working within the jail and in the community; and 2) The continuum of care should be structured according to the needs of the local community. Local advisory boards have been established to advise on needs assessment and service planning. In FY 2011 the MCCJTP operated in 22 Maryland counties. The program received an estimated total of 6,750 referrals from which an estimated 5,370 received treatment. From a combination of State and local funding the program anticipates providing over 5,000 hours of psychiatric services, nearly 17,000 hours of combined individual and group psychotherapy, and more than 16,000 hours of case management. While MCCJTP is unable to track recidivism from county to county until information technology is in place, the current recidivism rate is estimated to be between five percent (5%) and ten percent (10%).

In addition to working with the counties, MHA continued to partner with Baltimore City CSA to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). FAST also diverts individuals from jail and connects them to services. In FY 2011 FAST screened 976 individuals and conducted 515 face-to-face assessments for program appropriateness and expects to monitor more than 55 individuals in the community as part of a court ordered release plan. Additionally, the Forensic Assertive Community Treatment Team (FACTT), a specialized ACT team, served 130 individuals in FY 2011. Thirteen new clients were discharged from the State hospital.

Maryland's efforts to address the issues of individuals with mental illnesses in the criminal justice system were also driven by legislative actions, which led to the establishment of various workgroups. The group was charged with exploring issues targeted at "breaking the cycle of re-arrest and re-incarceration" for individuals with mental illnesses. Now formed as the Mental Health and Criminal Justice Partnership (MHCJP), this group includes representatives from the Department of Public Safety and Correctional Services (DPSCS), Mental Hygiene Administration (MHA), Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR), mental health professionals, legal, correctional, social service, and mental health consumer and advocacy communities. Their mission is to identify services that aid in reducing recidivism to detention centers. In June, the Subcommittee on Training presented eight objectives from which six were adopted by the Police and Correctional Officers Training Commission (PCTC) for inclusion in annual training.

Also, the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council, in collaboration with the Mental Health & Criminal Justice Partnership and the Interagency Forensic Services Committee, continued to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system.

Additionally, MHA submitted a report detailing its plan to enter into memoranda of understanding with local detention centers to establish a data sharing initiative. MHA and DPSCS continue to move forward on DataLink, an electronic interface to improve mental health services for individuals in the PMHS who have been arrested. Maryland's Department of Public Safety and Correctional Services (DPSCS) sends, within 24 hours, notification to ValueOptions® Maryland (VO) which receives notices of arrested individuals for each participating county and extracts the data for individuals who are in the PMHS. Through a secure file exchange, the CSAs and the detention centers are then notified of consumers within their jurisdictions who have been arrested. The notification includes information for the medical service provider at the detention center on diagnosis, mental health treatment provider, and prescriptions filled within the previous nine months. The goal is to have this linkage available to all county detention centers that participate in DPSCS' automated file transfer system. ValueOptions has worked with Baltimore Mental Health Systems (Baltimore City CSA who recently established a successful Data Link interface within their jurisdiction) since November 2010 to configure software and establish file transfer protocols to enhance this connection between VO and DPSCS. The Secretaries of MHA and DPSCS both have made continuity of services a priority for those individuals entering the criminal justice system, as well as those returning to the community. DataLink is expected to assist in enhancing this priority.

Services to the Homeless - Project for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care funds will be used to continue to meet the needs of homeless individuals and those coming from detention centers. This year, MHA will continue to work with courts, detention centers, public safety, and correctional services to better address the mental health needs of individuals entering or exiting these systems, as well as the needs of individuals in MHA facilities who are court-involved and ready for discharge. Additionally at this year's 2011 National Block Grant/Olmstead/ Data Infrastructure Grant Conference, MHA's Director of the Office of Special Needs Populations presented on "Implications of the Medicaid Expansion for Individuals with Criminal Justice Involvement".

The PATH program provided services in all 23 counties and Baltimore City in FY 2010. In SFY 2009, the funding level was \$1,172,000. In FY 2010, PATH was increased by \$140,000 which funded SOAR Outreach Specialists in Baltimore City and Prince George's County and a Data and Evaluation Consultant. In FY 2011, PATH will be funded at \$1,287,000, and is projected to enroll an estimated 2,402 individuals and families. Local PATH supported agencies identified 3,632 homeless individuals with mental illnesses. Of these, 1,949 actually enrolled for PATH services. **(Criterion 4)**

In FY 2011 Shelter Plus Care Housing grant was renewed for \$4,529,532 for 19 Shelter Plus Care renewal grants. For FY 2012, MHA was awarded funding in the total amount of \$4,542,852 for the Shelter Plus Care renewal grants. The renewal grant award was slightly increased due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants. In previous years, MHA was renewed for 22 grants from HUD however, in FY 2011 HUD merged grants in counties with multiple Shelter Plus Care programs. Currently, MHA is receiving 19 grants from HUD, and is serving a total of 637 persons, 136 single individuals with mental illness, 189 families with 312 children and 3 other family members through all of the Shelter Plus Care grant programs.

Another important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to the MHA to provide substance abuse and mental health services for people who are homeless. The grant enables communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (substance use disorders and mental illness).

SSI/SSDI Outreach, Access, and Recovery (SOAR) - Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. The purpose of SOAR is to expedite and increase the number of successful SSI/SSDI applications for all eligible applicants. In FY 2011, MHA continued to expand the SOAR initiative. In addition to the existing work groups in Baltimore City, Anne Arundel, Howard, Montgomery, Prince George's, and the Lower Eastern Shore counties (Somerset, Wicomico, and Worcester), MHA has held start up meetings and provided on-going support to work groups in Baltimore, St. Mary's, Harford, Washington, Garrett and Allegany counties and with Maryland's Department of Veterans Affairs.

During FY 2011, over 135 applications have been submitted within Maryland using the SOAR process. This is more than double the number that were submitted in FY 2010. The overall approval rate for initial applications across the state is 84% within an average of 62 days. Baltimore City, which has submitted the most applications, has a 96% approval rate for new applications and Montgomery County has a 100% approval rate for all its SOAR applications.

Five 2-day Stepping Stones to Recovery trainings were held in FY 2011, training over 140 case managers, mental health professionals, and social workers. Additionally, three specialized one and a half day SOAR trainings were held for Social Workers working in the state prisons and hospitals and a one day Refresher training was held for Prince George's County staff.

In FY 2011, through the use of PATH funding, MHA was able to fund two SOAR outreach positions, two SOAR coordinators and a part time Data and Evaluation coordinator. These positions will continue to be funded during FY 2012. It is anticipated that the focus in FY 2012 will be to strengthen those counties that are currently implementing SOAR, or who have already actively begun the planning process, as well as to explore the feasibility of extending SOAR into additional counties. In order to ensure the continuing high quality of SOAR applications, MHA is seeking to introduce a certification program in FY 2012.

Rural - See discussion on page 42.

Peer Run Services for Lesbian, Gay, Bi-sexual, Transgendered and Questioning (LGBTQ) - The Office of Consumer Affairs (OCA) works to gradually increase the sustainability and accountability of the 25 Wellness & Recovery Centers (formerly known as drop-in centers) currently established across the state. The LGBTQ Wellness & Recovery Center has offered several outreach sessions during the fiscal year on topics such as: “The Gay Community and Stereotypes”; Mental Health First Aid; and a workshop on community resources for the LGBTQ consumer for individuals who are homeless with mental illness. There will be an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community. In FY 2011, an annual meeting of the CSA directors and the directors of Wellness & Recovery centers was held to re-establish effective communication and continue to develop cohesive strategies to enhance the recovery process through collaborative leadership training. Many other consumer-run support groups are held in the centers on a regular basis. Many of these centers address issues of co-occurring disorders of mental illness and substance abuse within their programming.

Services for the Deaf or Hard of Hearing - The Director of MHA’s Office of Special Needs Populations, in collaboration with CSAs, works with community-based programs, the state hospital and the Governor’s Office of the Deaf & Hard of Hearing (ODHH) Advisory Council to coordinate community and inpatient services for persons who have a serious mental illness (SMI) and are deaf or hard of hearing. MHA currently operates a separate unit at a State hospital for deaf consumers in need of hospitalization. The unit provides full accommodations for deaf consumers and employs a full complement of mental health professionals who are fluent in American Sign Language. MHA also provides funding to CSAs to contract with providers in order for deaf consumers to access outpatient treatment, psychiatric rehabilitation services, case management, and residential rehabilitation services which have interpreters and/or staff fluent in American Sign Language and provide technical assistance and consultation. Additionally, limited outpatient clinic and residential rehabilitation services are available to individuals who have a SMI who are deaf or hard of hearing through the fee-for-service system.

In FY 2011, MHA hosted and participated on a behavioral health subcommittee, comprised of representatives from MHA, the Alcohol and Drug Abuse Administration, the Developmental Disabilities Administration, behavioral health providers, the Maryland State Department of Education, consumers, family members, and advocates. In FY 2010 the behavioral health subcommittee drafted minimum criteria for providing behavioral health care for Marylanders who are deaf or hard of hearing. Additionally in FY 2010, the subcommittee drafted recommendations to MHA’s ASO regarding standards for public mental health providers certifying proficiency and cultural competency in serving consumers who are deaf or hard of hearing. In FY 2011, the behavioral health subcommittee revised and resubmitted its recommendations the Deputy Director of Behavioral Health and Disabilities for review and approval. MHA served as the lead bringing together the partners at MHA, ADAA, and DDA and also served as the Department of Health and Mental Hygiene’s representative on the Maryland

Advisory Council for Individuals who are Deaf or hard of hearing. The behavioral health subcommittee also drafted informational materials on American with Disabilities Act, as well as tips for local hospitals (emergency departments) on assessing the needs of individuals who are deaf or hard of hearing who are seeking services and providing timely access to culturally sensitive and appropriate linguistic and communication services.

Also in FY 2011, MHA worked with Springfield Hospital Center (SHC) to re-institute the service providers review board, comprised of SHC social work staff, ADAA, DDA, and MHA funded residential programs, and staff from the three state behavioral health authorities. The service providers review board discussed the community needs of specific patients and coordinated a service plan which consisted of housing and services to facilitate a successful re-entry into the community for patients leaving the hospital. MHA continued to work with the Office of Deaf or hard of hearing (ODHH) Advisory Council and the CSAs to develop strategies to improve access to outpatient treatment and improving the competencies of outpatient providers working with consumers who are deaf or hard of hearing. In March 2011, MHA's Office of Special Needs Populations held a one-day conference "Helping Individuals to Lead Better Lives". The Governor's Office of Deaf or hard of hearing presented two afternoon workshops on cultural sensitivity and awareness for providers working with individuals who are deaf or hard of hearing, which was well received. Additionally, in May 2010, MHA hosted a cultural sensitivity and awareness training for behavioral health providers, CSAs, consumers, and advocates on understanding issues faced by consumers who are deaf or hard of hearing, and will offer future trainings in collaboration with the Governor's Office of Deaf or hard of hearing to increase awareness and understanding of providers in working with individuals who are deaf or hard of hearing and have a serious mental illness.

MHA also fosters the involvement of consumers and advocates in the planning process. Consumers, who are deaf or hard of hearing, and advocates are invited and have actively participated in the MHA annual State Plan Development Stakeholders meeting.

COMBINED ADULT AND CHILD TRAINING AND IMPROVEMENT ACTIVITIES

Trauma Informed Care - In June of FY 2011, a committee was formed to implement Senate Bill 556/House Bill 1150 regarding training in trauma-informed care and to conform to trauma-informed care principles. In addition, the law requires individuals to report abuse under specified circumstances and requires State facilities to report complaints of sexual abuse or sexual harassment to the State designated protection and advocacy system. In FY 2012, the Mental Hygiene Administration will implement a pilot program in State facilities to provide clinical, direct care, and other staff with regular patient interaction.

Smoking Cessation - Maryland was one of only a half-dozen states selected by SAMHSA to participate in a Leadership Academy for Wellness and Smoking Cessation Summit. As such, the State received the assistance of the nationally renowned Smoking Cessation Leadership Center (SCLC) for a summit focused on reducing smoking prevalence among people with behavioral health disorders. The purpose of the two day session, held on May 31 and June 1, 2011, was to design an action plan for Maryland to reduce smoking and nicotine addiction among behavioral

health consumers and staff, and to create an environment of collaboration and integration among the fields of public health (including tobacco control and prevention), mental health and substance use prevention. Under the leadership of DHMH Deputy Secretary for Behavioral Health and Disabilities, an integrated strategy was developed and is now in the implementation phase with clear goals established for the next three years.

First Responders - MHA, in collaboration with law enforcement agencies, offers training for officers, other public safety officials and community providers regarding the management of crises involving persons who appear to have a mental disorder and who may or may not have committed an offense. Training is provided through the MHA Office of Forensic Services, as well as by the local crisis response systems. Presentations include use of emergency petitions, approaching persons with mental disorders, the field interview of the person with a mental disorder, interacting with the suicidal individual, coverage of post traumatic stress disorder (PTSD) and treatment resources for active duty personnel and veterans. These presentations concentrate on the practical decisions that police officers have to make in the field, and are in plain, non-technical language. MHA will continue to participate in meetings with stakeholders regarding availability of mental health services for individuals with criminal justice involvement and on current or new programs and services provided by MHA's Office of Forensic Services such as diversion, services for inmates with mental illness, and discharge planning for pre/post release inmates. The Office will continue to provide training to MHA facilities and community forensic evaluators on the new reporting requirements for individuals committed as Incompetent to Stand Trial.

In collaboration with DHR, MHA, through the CSAs, has participated in the implementation of the Mental Health Mobile Crisis and Stabilization Service Initiative. This initiative provides community-based, 24-hour intensive in-home services to respond to crisis issues in foster/kin homes where DSS has placed children or for children who continue to reside with their families as a result of family team meeting intervention. In addition, Maryland has a comprehensive crisis response system in various jurisdictions which include metropolitan areas and major rural jurisdictions.

Implementation of the Mental Health First Aid (MHFA) Program - MHA, in collaboration with the Mental Health Association of Maryland and On Our Own of Maryland, has started to educate the general public to recognize signs of an emerging mental illness or a mental health crisis through the Mental Health First Aid® (MHFA) program. Maryland's effort is led by four regional coordinators who are housed within local Mental Health Associations. These coordinators carry out marketing and community outreach functions and provide oversight and technical assistance to the certified Instructors. More than 1,800 Marylanders have been trained during 75 sessions held by a corps of more than 60 certified instructors. The program is offered across Maryland in a variety of settings, including schools and universities. The Australian-based program was adapted for use in the United States through a collaborative effort among MHA, the Missouri Department of Mental Health and the National Council for Behavioral Healthcare. On Our Own of Maryland, Inc. contracted with seven nationally known

consumer leaders, from seven different states, to provide feedback and input on the MHFA manual.

State Disaster Planning and Training Activities - MHA's Office of Special Needs Populations provides facilitation, support and technical assistance to enhance Maryland's ability to respond to the behavioral health needs that arise in the event of natural or man-made crises/disasters as well as enhance MHA's and Core Service Agencies' (CSA) planning and preparedness. The Office reviews, facilitates updates and revisions to the All-Hazards Mental Health Disaster Plans for MHA and all the Core Service Agencies and provides technical assistance and consultation on behavioral health emergency preparedness. Currently, MHA's All Hazards Plan is up-to-date and MHA is working with CSAs to review and complete their annual updates. Recently, MHA has been working with the FEMA Region III Disaster Behavioral Health Coordinators and Braintree Solutions Consulting, Inc. to examine the newly developed disaster behavioral mental health operational plan template created for the Region III states (DC, DE, MD, PA, VA, and WV) and the best practices disaster behavioral mental health training curriculum. MHA will facilitate discussions and coordinate with DHMH's Office of Preparedness and Response and Braintree Solutions the review of MHA's current All Hazards plan and training approach and will make updates in alignment with FEMA III region's All Hazards plan and training curriculum. Additionally, MHA participated in the Region III Disaster Behavioral Health Consortium Conference on June 21, 2011 which began discussions of developing a certification program for disaster mental health responders.

The Office provides training to the Maryland Professional Volunteer Corps (MPVC) and assists the MPVC in their recruitment of additional disaster behavioral health volunteers. Training was conducted on Behavioral Health Considerations: Survivors and Responders on December 16, 2010 for MPVC volunteers. In addition, the office has conducted or provided technical assistance in identifying trainers to conduct disaster behavioral health trainings to CSAs as well as to other state agencies. Recently, on June 30, 2011, the office presented at Baltimore County's Emergency Preparedness for Clients with Disabilities Conference. The office's Behavioral Health Disaster Coordinator also served at the State Emergency Operations Center (SEOC) during any event which causes the SEOC to be activated.

In response to a request from the Office of Consumer Affairs, the office developed and implemented four train-the-trainer programs for lead staff at Maryland's On Our Own Wellness and Recovery Centers, incorporating disaster behavioral health and basic disaster preparedness concepts into the WRAP approach to health and well being for persons with mental health challenges in FY 2010. Participants included mental health consumers, Board members, interested general public participants, and representatives from NAMI.

Resilience: From Theory to Practice - MHA in collaboration with CSAs have sponsored regional trainings for administrators, clinical supervisors and lead staff of outpatient mental health clinics on the PMHS's commitment to resilience and its core concepts. Efforts are underway to explore the development of a training module to integrate the recovery and resilience concepts.

Family Training - In addition to the Family Leadership Institute (FLI) described in a prior section, the Maryland Coalition of Families provides two specific training curricula to families, Navigating the Juvenile Justice System and Navigating the Transition Years. Both of these training courses are reimbursable under the Medicaid waiver for family members of waiver service recipients, but these trainings are also considered essential for family members working as Family Navigators and as Family Peer-to-Peer Specialists under the waiver.

Local Training - MHA also supports training through its CSAs. Local/regional trainings are provided dependent on local needs. Consumer, family, and advocacy groups receive funding to provide community education and training which target adult consumers, minorities, family members, children's mental health, and stigma issues.

State Training - Activities for training and technical assistance are approved by MHA, and coordinated through the University of Maryland Training Center. Training events include projects for children and adolescents, adults and elderly consumers, as well as a multitude of special needs populations.

Cultural and Linguistic Competence - Maryland is especially cognizant of the need for cultural competence training and development of a workforce that includes people from many different cultures. Maryland is a diverse state, with a high concentration of African Americans and people from other countries, speaking a wide variety of languages. In 2008, the U.S. Census Bureau estimated that 28.7% of Maryland's population were Black or African American, while 6.4% were Hispanic or Latino (any race). In 2008, it was estimated that 12.3% of Marylanders were foreign born and 14.9% spoke a language other than English at home. Corresponding statistics for the U.S. as a whole were: 12.9% Black or African American, 15.8% Hispanic or Latino, 12.5% foreign born, and 19.6% speaking a language other than English at home. As a result, Maryland is especially cognizant of the need for cultural competence training and development of a workforce that includes people from many different cultures.

Under the leadership of the Deputy Secretary for Behavioral Health and Disabilities, Renata Henry, Maryland participated in a SAMHSA-sponsored policy academy on health disparities for behavioral health and Maryland is currently making changes to its system to address these issues.

In another approach to advance the Cultural and Linguistic Competence Initiative, MHA and the Mental Health Transformation Office (MHTO), have developed and implemented the Cultural and Linguistic Competence Leadership Academy. This Academy is designed to assist organizations in Maryland with the incorporation of cultural and linguistic competence as an integral aspect in their organizational structure and operation. Implemented as a pilot project, this initiative involves the recruitment and training of individuals who will become "leaders" of change within their specific organizations. The "leadership team" includes management and direct care staff representatives and two consumers from each site. The project was a five day training June 2009 to September 2010 and targeted organizational change within the selected provider programs and the collection of data to assess the impact of the training on consumer and program staff perception of cultural competence and the process of consumer recovery. Data analysis, along with the actual training and technical assistance, supported the development of an action plan to be utilized by the participating programs to move services and treatment toward cultural competence.

BI-DIRECTIONAL INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES

Under the direction of the Deputy Secretary for Behavioral Health and Disabilities (BHD), the three administrations MHA, ADAA, and the Developmental Disabilities Administration, DDA) have improved collaboration and meet on a regular basis to discuss training, health disparities, and data. The Office of the Deputy Secretary is working toward the goal of expanding the development of a system of integrated services including substance abuse, mental health, developmental disabilities, and somatic care.

The MHA and ADAA, in collaboration with Medicaid, Managed Care Organizations and the PMHS's Administrative Services Organization (ASO), have formed the Coordination of Care Committee to address information technology and service integration issues at the administrative, policy, and provider levels. This committee provides input to policy development with Medical Assistance (MA), addresses the role of the Federally Qualified Health Centers (FQHCs, and offers consultation as needed. The MHA and the ADAA each work with a consortium of directors who meet monthly to maintain ongoing communication and support between the state's leadership and the medical leadership of the community outpatient mental health centers (OMHCs) and substance abuse programs. Discussions include efforts to coordinate and integrate behavioral health and primary health care services.

Research at the University of Maryland and at Johns Hopkins-Bayview has demonstrated that a high percentage of consumers view their mental health provider as their primary source of health care, and some (approximately 1/3) do not access their MCO for primary health care at all. As a result, both institutions are exploring the integration of somatic health care into behavioral health services for individuals who do not choose to access services through a primary care provider.

Maryland is exploring a variety of integration options through the Coordination of Care Committee. A recent study by the Milbank Memorial Foundation has noted a number of models that can work, and the pros and cons of each. One model promotes the primary care sector as the patient's health home, with either full integration of behavioral health services, or referral out to specialty care for behavioral health care. Another model promotes behavioral health providers serving as the health home, with either full integration or referral out for primary care. There will be a need for a variety of options based on the needs and choices of each individual consumer.

Maryland has used the four quadrant model in its work on co-occurring disorders and finds it to be a useful guide for discussions regarding the integration of behavioral health and primary care services:

- **Quadrant I: Low Behavioral and Physical Complexity/Risk** – served in primary care with behavioral health staff on site.
- **Quadrant II: High Behavioral Health, Low Physical Health Complexity/Risk** – served in a specialty behavioral health system that coordinates with the primary care provider, or in more advanced integrated systems, that provides primary care services within the behavioral health setting.
- **Quadrant III: Low Behavioral, High Physical Health Complexity/Risk** – served in the primary care/medical specialty system with behavioral staff on site in primary or medical specialty care, coordinating with all medical care providers including disease care managers.
- **Quadrant IV: High Behavioral, High Physical Health Complexity/Risk** – served in both the specialty behavioral health and primary care/medical specialty systems.ⁱⁱⁱ

Additionally, local efforts on integrated health have been implemented. Mosaic Community Services, a private, non-profit organization specializing in serving individuals and families with mental illness and substance use issues, recently received a grant from the Maryland Community Health Resources Commission to hire a somatic care nurse practitioner and a case manager to do assessments and triage individuals who have not seen a somatic primary care provider for 6 months or more. Integrating somatic care, mental health, and addiction services is a priority goal for Mosaic. Also, Mosaic was one of fifteen organizations selected to participate in SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) Learning Collaborative. The Collaborative provides a learning environment for the selected community mental health and addiction providers to assess, build, and share outcomes related to their organizations' efforts to integrate behavioral healthcare and primary care. CIHS is run by the National Council for Community Behavioral Healthcare

PROVISION OF RECOVERY SUPPORT SERVICES FOR INDIVIDUALS WITH MENTAL OR SUBSTANCE USE DISORDERS

Moving Forward with Maryland's Mental Health Transformation

The state of Maryland continues to refine strategies to achieve organizational culture change that will transform the delivery of behavioral health services and fully support recovery and resilience for consumers. As Maryland completes the sixth and final year of the Transformation grant, many projects have been sustained and many more have reached a level of momentum that the state is confident will continue beyond the life of the grant. MHA continues to transition services to individuals and organizations outside the Transformation Office, thereby sustaining MHT-SIG efforts.

As part of the Government Performance Reports Act (GPRA), seven GPRA infrastructure indicators were developed to measure system changes for all the transformation states. Maryland has achieved significant progress:

- Made over 24 significant policy changes, including five regarding the financing of mental health-related services
- Trained over 13,177 individuals in mental health best practices
- Made over 107 significant organizational changes to support transformation
- Expanded data accountable systems across a total of 69 jurisdictions and organizations
- Implemented state-of-the-art mental health practices relevant to the New Freedom Commission goals in over 338 programs.

Sustainability for any system transformation is defined not only by its ability to develop financing strategies, but also by its ability to grow grass-roots support, cultivate cultural competence, and grow leadership within consumer, youth, and family partnerships. All of this can be reflected in responsive policy and regulations. When Maryland received the Transformation grant, leadership developed a methodical strategy for implementation. Transformation selected projects that were ready to be implemented, had a plan for sustainability, and reflected MHA's value set. All projects were selected because they would produce lasting and sustainable changes in Maryland's public mental health system. Initiatives that at first seemed unrelated, have now been knitted together to form a system that is consumer-driven and recovery and resiliency based. Maryland has developed a three pronged approach to sustaining the momentum of Transformation: 1) Projects were staffed with individuals/agencies who could serve as champions beyond the life of the grant; 2) Recovery principles were embedded into every aspect of the mental health system; and 3) Training and technical assistance built the State's knowledge base and the number of available experts increased.

MHA, in collaboration with On Our Own of Maryland (OOOMD), will continue statewide delivery of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement, and continue to incorporate WRAP within community mental health programs. The Plan also addresses our increasing efforts to actively involve consumers and families in quality improvement and evaluation activities.

The Consumer Affairs Liaison within the Office of Consumer Affairs (OCA) is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP) which has been funded by the MHA since 1990. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates and play a prominent role within state and local policy-making bodies. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state.

MHA continues to promote recovery in all aspects of the behavioral health care system. Recovery Centers of Excellence address in-depth program change within community mental health programs. Initially, four provider agencies, including consumer participation, received consultation, intensive technical assistance, and training in specific curriculum modules to assist them to move toward a transformed, recovery-oriented organization. Upon completion of the

program, agency trainees were presented with certificates and they will now serve as mentors to other agencies wishing to implement the program. Other discussions on consumer recovery supports are presented in Section L of this document.

ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS

Overview of the State's Behavioral Health System:

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. Specialty mental health care is carved out from physical care and is administered by MHA.

MHA operates five inpatient psychiatric facilities and two residential treatment centers for children and adolescents. From the time of admission, facilities work collaboratively with CSAs, community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual's medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland.

The Public Mental Health System (PMHS) is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. In September 2009, MHA began a five year contract with ValueOptions, Inc., the ASO, for Maryland's PMHS, referred to as ValueOptions® Maryland. The major responsibilities of Value Options include: access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services, and stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice

MHA and CSAs share responsibilities in the PMHS. There are nineteen (19) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service. Additionally, CSAs are important points of contact for both consumers and providers in the PMHS and develop partnerships with other local, state and federal agencies. CSAs provide numerous public education events and trainings. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. Additionally, local mental health advisory committees and CSA

Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities. Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve. CSAs also serve as authorization agents for some specialized services and play point leadership roles in a number of federally funded local demonstration projects.

Alcohol and Drug Abuse Administration (ADAA) - The ADAA is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention and treatment services. As the Single State Authority (SSA) for Maryland, the ADAA is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The ADAA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families and communities. The ADAA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and aftercare services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates “science to service” information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence, and support services to sustain recovery beyond the treatment/rehabilitation episode..

IDENTIFY UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

MHA uses several sources of data to identify unmet service needs and gaps. The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). The ASO data systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on a July-June fiscal year. Over 50 standard reports are generated to assist in general planning, policy, and decision making

Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Data, when available is shared with the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. Special state reports on individuals with co-occurring illness show that they consume a disproportionate share of PMHS resources. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability. The PMHS data system is discussed in detail in Section E.

There is general consensus that the benefit package in the PMHS is more comprehensive than the limited mental health services provided under many private health insurance plans; however, there continue to be concerns among all stakeholders that maintaining access to services at this time of national and state economic crisis will be challenging. The issues raised are about the number or location of service programs, as well as the availability of highly specialized treatment services. Recent discussions have centered on continuous improvement in the quality of services; assuring that services are effective, recovery focused, and consumer driven; and that those most in need are able to receive the services. Coordination of care between somatic and psychiatric sectors remains critical. Several strategies in the State Plan focus on the need to coordinate care between providers in the public mental health system and primary care providers in the managed care organizations responsible for the management of the primary health and mental health needs of individuals.

The identification and assessment of strengths, needs and existing resources has been implemented through a variety of approaches. One approach was through Maryland's Mental Health Transformation State Incentive Grant (MHT-SIG). In 2006, as a requirement of each the MHT SIG, each State was mandated to conduct a thorough Inventory of Resources and a Needs Assessment. This requirement for a comprehensive systemic review was accomplished through a variety of information gathering mechanisms. They included a series of interviews with key administrators in State agencies, a number of group interviews and focus groups with adult consumers, youth consumers, families, providers, and other stakeholders; a series of public forums and hearings; and a review of existing written materials.

While this assessment of resources was conducted in 2006 through the transformation grant, there are a few areas that have been updated, such as listings under resources and strengths, to reflect current events. We have made great strides in introducing promising practices that support recovery and resilience. Many of the findings are still relevant today. Maryland is moving forward with implementation of health care reform in developing and delivering state-of-the-art behavioral health services.

INVENTORY OF RESOURCES AND NEEDS ASSESSMENT - SUMMARY OF KEY FINDINGS

The following information briefly summarizes the findings of the report by topical areas contained in the chapters of *Section II* of the full report.^{iv} Some of the language has been updated or modified to reflect the current system.

LEGISLATION / REGULATIONS / POLICIES

Resources/Strengths

- The Maryland State General Assembly has recently enacted a number of laws facilitating the provision of mental health services in Maryland. These include laws related to training in assisted living programs, suspension rather than termination of benefits for individuals entering a psychiatric hospital, housing development assistance for individuals with disabilities, and laws related to competency hearings.
- One key piece of legislation from 2004 established the Maryland Department of Disabilities (MDOD) as a Cabinet level entity, the first overarching coordinating entity of its kind created nationally. This legislation was a signature policy initiative of the former Governor. Among the many provisions of the legislation is the mandate for the completion of a broad State Disability Plan to integrate disability policy for Maryland, the creation of a cabinet structure for people with disabilities, the Interagency Disability Board, and a gubernatorially appointed cross disability advisory structure, the Maryland Commission on Disabilities, to advise the new department in its functions.
- The Mental Hygiene Administration (MHA) had implemented a new policy in which the emphasis of the service authorization process carried out by the administrative services organization (ASO) shifts from care management at the individual consumer level to monitoring outcomes and service utilization at the program level.
- In 1978, Maryland was the first state to establish a children's cabinet structure (MD Article 49 D, 1978). In subsequent years, the Governor's Office for Children, Youth and Families (GOCYF) was established to both staff and chair the Subcabinet for Children, Youth and Families. This authorizing legislation expired in June 2005, at which time the former Governor reconstituted the former GOCYF as the Governor's Office for Children (GOC) and reestablished the former Subcabinet as the Children's Cabinet, composed of the Cabinet Secretaries of the Department of Health and Mental Hygiene (DHMH), Maryland Department of Disabilities (MDOD), Maryland State Department of Education, Department of Human Resources, Department of Juvenile Services, and the Department of Budget Management.

Needs/Challenges

- There was an expressed need for parity between mental health and somatic services under private insurance policies.
- The need to respond to multiple regulatory agencies often with similar but not quite the same requirements is frustrating and time-consuming for providers.
- The opinion was strongly stated by providers that regulations often prevented the use of useful and innovative interventions such as telepsychiatry.

Suggestions

- COMAR regulations that govern programs need thoughtful re-evaluation. They should reflect standards and the process of Recovery.
- Mandate mental health screening.
- Core Service Agencies (CSAs) should be more integrally involved in the operation of the mental health system.

SERVICES / PROGRAMS / PRACTICES: TREATMENT SERVICES

Resources/Strengths

- A wide variety of mental health services are provided within the Public Mental Health System (PMHS) fee-for-service system.
- Maryland has implemented several Evidence-Based Practice (EBP) and best practice programs including Assertive Community Treatment (ACT), Supported Employment, Family Psychoeducation and Wraparound services.
- Initiatives also exist to address the needs of young children, transition age youth, older adults, individuals who are deaf or hard of hearing and individuals with traumatic brain injury.

Needs/Challenges

- There is a lack of mental health services for transition age youth and older adults.
- Over-utilization of Emergency Rooms (ERs) is a major problem and consumers are getting “stuck” in ERs due to lack of available inpatient beds.
- It was reported that services were confusing and difficult to access overall.

Suggestions

- Increase service accessibility by creating “one-stop-shops” or educating people about how to navigate the system.
- Identify State Agency responsibilities in the continuum of care and services.
- Expand mental health services, including early intervention and prevention, school-based programs, services for transition age youth and services for older adults.
- Measure outcomes, provide programs with clinical information and outcomes, develop benchmarks and give feedback to providers.

SERVICES/PROGRAMS/PRACTICES: COMMUNITY SUPPORTS

(Specific subsections include: {1} housing/homelessness; {2} employment and education/training; {3} peer support; {4} State Agency community programs; and {5} transportation)

Resources/Strengths – Housing/Homelessness

- Several different initiatives and mechanisms exist to address housing needs for mental health consumers such as Section 8 Vouchers Flexible Housing Choice; licensed assisted living programs; residential rehabilitation programs; The Bridge Subsidy Pilot; and partnerships with community housing development organizations, mainstream housing developers and other non-profit housing agencies.
- Projects for Assistance in Transition from Homelessness and Shelter Plus Care funds are used to provide housing and support for homeless mental health consumers.
- The Governor’s Interagency Council on Homelessness is comprised of several State Agencies working to reduce homelessness in Maryland.

Needs/Challenges – Housing/Homelessness

- There is a critical shortage of affordable, safe, quality housing in Maryland.
- Background checks, credit histories and stigma are barriers to obtaining housing.

Suggestions – Housing/Homelessness

- Create more housing programs using a “Housing First” model and offering a continuum of supports.
- Require housing developers to “set aside” affordable housing for persons with psychiatric disabilities as part of their development plan.

Resources/Strengths – Employment and Education/Training

- Maryland is disseminating the Evidence-Based Practice (EBP) of Supported Employment.
- Maryland has also recently launched the Employed Individuals with Disabilities which is a Medicaid Buy-in program.
- The Maryland State Department of Education Division of Special Education collaborates with families, local early intervention systems and local school systems to ensure that all children and youth with disabilities have access to appropriate services and educational opportunities to which they are entitled under federal and state laws.

Needs/Challenges – Employment and Education/Training

- Supports and services that lead to competitive employment outcomes are not always valued at the highest level and throughout the entire disability services system.
- Financial disincentives to work exist.
- Some Individualized Education Programs (IEPs) for youth are inadequate preparation for transitioning to employment or post-secondary education.

Suggestions – Employment and Education/Training

- Explore strategies for helping individuals who are not successful in Supported Employment Programs get employment.
- Continue to support pre-employment programs for those individuals who are not yet able to work in an integrated environment.
- Provide career guidance and technical training for youth.

Resources/Strengths – Peer Support

- Consumer drop-in centers and training workshops conducted by On Our Own of Maryland, Inc. were identified as highly valuable.

- The Olmstead Peer Support Program enables peers to work part-time with patients in three State Hospitals.
- The family and consumer support programs offered by the National Alliance on Mental Illness – Maryland (NAMI-MD) were reported to be quite helpful.
- The Peers program was also identified as a valuable source of support for older adults.

Needs/Challenges – Peer Support

- The need for more peer support programs was identified.

Suggestions – Peer Support

- Assist consumer groups to become centers for wellness and recovery.
- Make peer support specialist services a Medicaid-eligible service.

Resources/Strengths – State Agency Community Support Programs

- Several State Agencies operate community support programs that may be helpful to individuals with psychiatric disabilities. These include programs for older adults, referral and assistance programs for individuals with disabilities, social service programs, and other resource centers for youth and families.

Needs/Challenges and Suggestions – State Agency Community Support Programs

- Any needs or suggestions identified related to these programs were either not specific to individuals with psychiatric disabilities or are described in several other areas of the report.

Resources/Strengths – Transportation

- Collaborative efforts have led to access to vehicles and publicly supported transportation.
- Some assistance with transportation is available for people with disabilities.

Needs/Challenges – Transportation

- Transportation is limited, particularly in rural areas.

Suggestions – Transportation

- Ensure that public transportation is available in all areas of the State.
- Provide funding for transportation.

WORKFORCE DEVELOPMENT AND TRAINING

Resources/Strengths

- Maryland is considered a leader in Workforce Development for Children's Mental Health.
- Several of the agencies that encounter individuals with serious emotional disturbance or serious mental illness provide cross-training to their staff members related to mental health issues.

Needs/Challenges

- Compensation was mentioned frequently as a barrier to staff recruitment in the PMHS.
- Staff shortages are acute in rural areas.
- There are no system-wide standardized competencies for direct care staff.
- The emphasis by the fee-for-service system on billable hours interferes with the ability of clinicians to participate in continuing education opportunities which are often required for continued licensure.

Suggestions

- Establish partnerships between colleges and universities and mental health stakeholders to explore providing students with incentives to enter mental health careers, focusing particularly on work with underserved populations and all age groups.
- Increase the number of multicultural and bilingual providers (including sign language).
- Add mental health competencies to requirements for professional licensure.
- Offer OOOMD anti-stigma training at professional schools.
- Teach staff in non-mental health agencies to understand behavior and identify mental health needs among the consumers they serve.

COLLABORATION

Resources/Strengths

- Several State-level councils and boards exist to assist in the planning and coordination of mental health services. Examples include: The Maryland Advisory Council on Mental Hygiene/PL 102-231 (Joint Council), the Children's Cabinet, and the Interagency Disabilities Board.
- Over 100 mental health-related committees exist in Maryland to address a variety of issues including early childhood programs, children's mental health, workforce development, cultural competence and self-directed care.
- Core Service Agencies, Local Management Boards, Area Agencies on Aging and Local Coordinating Councils collaborate at the local level to ensure that consumers' needs are met.

Needs/Challenges

- Lack of integration and collaboration between State Agencies as well as the public and private sector is a major challenge.
- Planning occurs in isolation; fragmentation leads to adversarial relationships.
- Some consumers, family members, and providers reported feeling excluded from planning and decision-making.

Suggestions

- Involve a wider variety of stakeholders in planning and decision-making.
- Develop a planning framework that combines agencies' planning, supported as appropriate by braiding the resources, in which key priorities are identified.
- Share information about available services and programs, leading to more effective and efficient programs, empowered providers, and a greater range of interventions.

CONSUMER / FAMILY INVOLVEMENT

Resources/Strengths

- The strength of Maryland's PMHS lies in large part with its long-term, well-organized and effective consumer, family, advocacy and provider organizations.
- The PMHS in Maryland is moving toward increased consumer/family responsibility and involvement in the planning, decision making and implementation of care.
- A growing strength of the PMHS is the effort to further include consumers and other stakeholders in the quality improvement and evaluation activities (e. g., Consumer Quality Teams).

Needs/Challenges

- There is a need to train the next generation of young adult leaders in the consumer movement.
- It is difficult to recruit additional consumers and family members to participate on committees.
- It is hard to convince consumers that they do have a voice and they do matter, particularly those who have had little contact with the consumer movement.
- Consumer run programs are not funded as well as provider programs.

Suggestions

- Examine methods for increasing the involvement of consumers/family members in State and local planning and policy activities (e.g., reimburse participation, provide transportation, etc.).
- Train stakeholder groups to use information on how to recruit consumers and what to anticipate to facilitate consumer involvement.
- Provide incentives for community providers to enhance independence and give clients choice.

FINANCING

Resources/Strengths

- In FY 2012, a total of \$1,061,067,808 has been appropriated for the MHA. Of this amount, \$793.4 million (\$681.5 million MA service funds) is for community services, \$259.2 million for State-operated institutions and \$8.3 million for program administration. (Seventy-four point eight percent (74.8%) of the FY 2011 funds are targeted for community services). Several local jurisdictions contribute mental health funding, which is not included in these budget numbers. In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This consists of approximately \$48.1 million in State general funds and \$27.2 million in federal funds. Federal grants include: this block grant, PATH, Shelter Plus Care, Data Infrastructure Grant (DIG), the Mental Health Transformation-State Incentive Grant, the new multi-year System of Care grant for children and other CMHS and CMS grants.
- Limited funding is also available within other State Agencies for provision of services to individuals with psychiatric disabilities.
- During FY 2005 (the latest year for which statewide information is available); Maryland State agencies participated in approximately 502 federal grant programs, receiving over \$6 billion. Medical Assistance accounted for nearly 42% of this total, at \$2.5 billion.

Needs/Challenges

Although the implementation of the managed, fee-for-service PMHS had the desired effect of increased access to services, keeping expenditures within appropriations is an ongoing challenge.

- Funding occurs in “silos” making collaboration and coordination of services across different State Agencies challenging.
- The fee-for-service system can limit creativity and innovation in service delivery.

Suggestions

- Integrate funding streams to enhance service accessibility and coordination.
- Pay for performance and outcomes; do not pay for ineffective services.
- Provide equal access to services regardless of insurance status.
- Educate consumers and family members on available benefits.

DATA AND MANAGEMENT INFORMATION SYSTEMS

Resources/Strengths

- A major strength of Maryland's PMHS consists of the data which are derived from the operation of the fee-for-service system, which funds nearly 95% of all community based services provided in the PMHS.
- Maryland will be implementing shortly a statewide Outcomes Measurement System (OMS) within the PMHS.
- MHA has access to a Hospital Management Information System (HMIS) which is used in all of the State psychiatric hospitals and residential treatment centers to track admission, discharge, census information and bed vacancies.
- The Medicaid Management Information System (MMIS) is a rich source of provider, consumer, and utilization information for Medical Assistance (MA) eligible individuals.

Needs/Challenges

- The ASO Management Information System (MIS) captures no data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source contributing to an undercount of persons with mental illness who are receiving publicly funded services.
- There is a lack of availability of "real-time" data from the MMIS as there is lag time between when a service is provided and when a provider submits the claim for payment.
- Health Insurance Portability and Accountability Act (HIPAA) and legal confidentiality issues create challenges for data sharing.

Suggestions

- Increase participation regarding data issues by advisory councils.
- Collect information about workforce measures, especially measures of salary, credentialing and retention.
- Identify of the number of individuals with mental illnesses who are involved with the criminal justice system who would be served better by a community mental health system.

FACILITIES AND EQUIPMENT

Resources/Strengths

- Mental health and substance abuse services existing in close proximity facilitate integrated referral and treatment.

Needs/Challenges

- There is a lack of adequate and available technology including computers and software.

Suggestions

- Enhance technology systems to be used across agencies to facilitate resource information and to track data.
- Purchase information technology for use across the system.

MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

(Specific subsections include: {1} reduction of stigma/suicide prevention; and {2} addressing mental health with the same urgency as physical health)

Resources/Strengths - (Reduce Stigma/Suicide Prevention)

- On Our Own of Maryland, Inc. has developed and implemented the nationally recognized Anti-Stigma Project (ASP) to address stigma within the mental health system.
- Suicide prevention activities in the State include the Maryland Suicide Prevention Program, a national model Youth Suicide Crisis Hotline, and an annual Suicide Prevention Conference.

Needs/Challenges - (Reduce Stigma/Suicide Prevention)

- Stigma represents a significant barrier to people utilizing the services and supports available.
- There is stigma associated with being a mental health provider, as well as among service providers.
- Maryland's Suicide Prevention Program has not been extended to the adult and older adult population.

Suggestions - (Reduce Stigma/Suicide Prevention)

- Develop a social marketing campaign with consistent messages about mental health in order to reduce stigma.
- Collect data on outcome measures related to suicide.
- Update the state youth suicide prevention plan in collaboration with MSDE, other appropriate agencies, families, and providers.

Resources/Strengths - (Address mental health with same urgency as physical health)

- There is a Maryland statute and accompanying regulations requiring coordination of care between Managed Care Organizations (MCOs) and the PMHS.
- There has been a considerable increase in school-based mental health services and in the availability of school-based health centers; in many cases, both behavioral and somatic health services are available to students.
- The requirement that MCOs provide primary mental health care provides a key linkage between a child's pediatric medical care and mental health treatment.

Needs/Challenges - (Address mental health with same urgency as physical health)

- There are time constraints on primary care providers (PCPs) such that mental health screenings are not completed unless they are mandated.
- There is a growing incidence of dementia and providers are having difficulty securing services for older adults with dementia because they are being denied entry into residential programs.

Suggestions - (Address mental health with same urgency as physical health)

- Collaborate with PCPs in the community in order to help them achieve better screening, assessment, and referral practices.
- Promote co-location of geriatric mental health and substance abuse services in primary care service settings.
- Use technology to integrate behavioral and somatic care.
- Offer funding for mental health programs at a level that is consistent with somatic health programs.

RECOVERY AND RESILIENCY

Resources/Strengths

- In NAMI's 2009 "Grading of the States" report, Maryland received a B in the category of recovery supports (e.g., supported employment, peer support programs, consumer quality teams, reducing use of seclusion and restraints).
- Stated objectives of the MHA in FY 2012 include increasing the abilities of individuals with mental illnesses to live successfully in the community and promoting recovery and resiliency.
- Several collaborative activities exist in the State to promote recovery and resiliency including the MHA Office of Consumer Affairs (OCA), the Wellness and Recovery Action Plan, the Leadership Empowerment Advocacy Project (LEAP) and a self-directed care task force.

Needs/Challenges

- Some stakeholders indicated that the PMHS is not focused on recovery and that it does not empower consumers.
- The notion of recovery is seen as ambiguous and providers expressed a need to determine individual-level criteria for defining the success of treatment.

Suggestions

- Reevaluate Code of Maryland (COMAR) regulations that govern programs so that they reflect the process of recovery.
- Define outcomes measures related to recovery and resiliency.
- Require resiliency/strength-based interventions training as a core competency.

CULTURAL COMPETENCE AND DISPARITY ISSUES

(Specific subsections include: {1} race/ethnicity; {2} rural populations; and {3} sexual orientation)

Strengths and Resources – Race/Ethnicity

- Health and human services agencies throughout Maryland have adopted the CLAS (Culturally and Linguistically Appropriate Services) standards.
- MHA-funded trainings are all required to include cultural competence.
- Within the PMHS, the MHA Cultural Competence Advisory Group works to ensure a more culturally competent PMHS and provides training regarding cultural sensitivity.

Needs/Challenges – Race/Ethnicity

- Language was consistently identified as a barrier to service provision and the need for bilingual service providers is great.
- Respondents indicated that the workforce needed to be more culturally diverse.

Suggestions – Race/Ethnicity

- Recruit more mental health providers from a wide range of ethnic and cultural backgrounds and who are bilingual, particularly those who speak Spanish.
- Include cultural competency in licensure and continuing education requirements.
- Use existing culturally competent programs as “best practices” models.

Strengths and Resources – Rural Populations

- Within the PMHS, the range of mental health and support services in rural counties is generally similar to those that are available in urban and suburban jurisdictions.
- Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations.

Needs/Challenges – Rural Populations

- There is a lack of mental health professionals in rural areas which is related to ongoing challenges in recruitment, retention and training of these professionals.
- There is a lack of specialty service providers, including crisis services.

Suggestions – Rural Populations

- Implement telemedicine for rural populations.
- Require a "rural impact statement" of all behavioral health rules, policies and initiatives retrospectively and prospectively, to ensure rural equality of access for individuals diagnosed with psychiatric disabilities.

Strengths and Resources – Sexual Orientation

- There is a support group in Baltimore City for mental health consumers who are gay, lesbian, bisexual, or transgender (GLBT).

Needs/Challenges – Sexual Orientation

- Gay and lesbian issues were not included in the President’s New Freedom Commission.
- There are providers who refuse to provide services to the GLBT population.

Suggestions – Sexual Orientation

No suggestions were provided for addressing the needs of GLBT mental health consumers.

INDIVIDUALS WITH MENTAL HEALTH PROBLEMS IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS

Resources/Strengths

- Maryland Community Criminal Justice Treatment Program (MCCJTP) provides incarcerated adult individuals with co-occurring disorders access to mental health treatment and comprehensive re-entry planning.
- The TAMAR (Trauma, Addictions, Mental health, And Recovery) Program provides treatment for incarcerated men and women who have histories of trauma and also have mental illnesses.
- The FAST (Forensic Alternative Services Team) is an important diversion program for individuals brought in to Baltimore City's Central Booking Facility who have no prior convictions of a violent crime and who have a diagnosis of a serious mental illness.
- Increase in the availability of mental health clinical care in juvenile detention centers.

Needs/Challenges

- There is a lack of communication and sharing of data between justice systems and other State providers.
- There is a lack of adequate mental health assessments and services in criminal and juvenile justice systems.
- There is a lack of a mental health diversion program in schools.
- Individuals with a mental illness and criminal record encounter discrimination.

Suggestions

- Encourage and invite consumer involvement to help transform mental health care in the legal system.
- Employ more assisted outpatient treatment teams in the community to decrease hospital and jail utilization.
- Expand mental health courts throughout the state to reduce revolving door between prisons and institutions and homelessness.

INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH PROBLEMS AND SUBSTANCE ABUSE PROBLEMS

Resources/Strengths

- An administrative officer from the DHMH Secretary's office has been appointed to work with both MHA and the Alcohol and Drug Abuse Administration (ADAA) resulting in a State-level leadership team to provide guidance toward enhanced service coordination across systems.
- The State of Maryland was selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in the National Policy Academy on Co-Occurring Disorders in September 2005 which resulted in the creation of a State Action Plan.
- Representatives from MHA and DHMH meet with county leaders to provide assistance and support for initiatives to implement the Comprehensive, Continuous, Integrated Systems of Care (CCISC) for Consumers with Co-Occurring Mental Health and Substance Use Disorders model.

Needs/Challenges

- The lack of coordination of care between the mental health and substance abuse systems is a major problem for Maryland. Separate programs, funding streams and regulations make treatment integration very difficult.
- Many individuals with co-occurring disorders inappropriately use the emergency room (ER) for short-term crisis intervention or detoxification services.
- There is a lack of specially trained clinical personnel to meet the needs of individuals with co-occurring mental health and substance abuse problems.

Suggestions

- Eliminate separate systems for mental health and substance abuse; integrate treatment for mental health and substance abuse.
- Develop shared funding streams for substance abuse and mental health.
- Create standard screening, assessments and levels of care and combine mental health and substance abuse screenings.
- Define outcomes measures related to co-occurring disorders.
- Address overuse of the ER for mental health and substance abuse services.

INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH PROBLEMS AND DEVELOPMENTAL DISABILITIES**Resources/Strengths**

- A special coordinator works within both MHA and the Developmental Disabilities Administration (DDA) to enhance the ability to meet the needs of individuals dually diagnosed with mental health problems and developmental disabilities.
- MHA and DDA have developed a training initiative regarding co-occurring disorders.
- DDA developed the "Ask Me!" system, in which individuals and families are surveyed throughout the year to express their desires, remove barriers and promote advocacy for their own plans.

Needs/Challenges

- There is no systematic way of determining if an individual is using both DDA and PMHS services.
- Providers and programs proficient in working with co-occurring mental illnesses and developmental disabilities are limited and the need far exceeds availability.
- Providers often have difficulties navigating the PMHS on behalf of consumers with developmental disabilities that also have mental health needs.

Suggestions

- Address the needs of individuals with co-occurring mental illnesses and developmental disabilities through creation of additional programs and specialized staffing in hospitals.
- Develop a joint MHA/DDA training initiative regarding co-occurring disorders.
- Implement a tracking system to monitor individuals who are court-committed to MHA or DDA facilities in order to allow oversight of progress in evaluation, treatment and release planning.

TRAUMA AND DISASTER PREPAREDNESS

Resources/Strengths

- The Trauma, Addictions, Mental health, and Recovery Program (TAMAR) provides trauma-specific services to men and women who have histories of childhood physical and/or sexual abuse, co-occurring disorders, and are involved in the criminal justice system.
- Ongoing trauma-informed training is provided to community and inpatient providers.
- The Hotline Online Tracking System (HOTS) can be used to broadcast messages to all of the State hotlines so that callers may receive needed information during a crisis or emergency.

Needs/Challenges

- There are Insufficient trauma services for youth.
- There is a need for trauma-informed service training for law enforcement, social service agencies, and emergency room personnel

Suggestions

- Create policies so that all law enforcement officers receive trauma-informed training regarding interacting effectively.
- Ensure persons with serious mental illnesses have access to psychiatric medications in an emergency or disaster situation.

Additionally, the Maryland's CSAs also link their needs assessment findings and PMHS data trends to developing goals and strategies at the local level. Information from the CSA local plans assists State's mental health planning process. Overall findings include needs/gaps in the following areas:

- Housing
- Transportation
- Co-occurring (mental health and substance abuse)
- Stigma education
- Workforce development to address shortages in mental health professionals, particularly in rural/remote areas
- Crisis response and emergency care

As stated previously, DHMH's mental health and substance abuse administrations (MHA and ADAA) will explore the possibility to develop a joint behavioral health needs assessment process to identify behavioral health needs across the State.

PRIORITIZE STATE PLANNING ACTIVITIES**THE STATE’S PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS AND CRITICAL GAPS**

One of Maryland’s priorities for the PMHS is the need to maintain continuity and access of services despite fiscal challenges. This year several state strategies address efforts to improve coordination of care in the PMHS. MHA will continue to strengthen the ongoing collaborative work among the ASO and managed care organizations (MCOs), as well as collaborate with the University of Maryland, School of Medicine, Department of Psychiatry, to research best practices in psychiatry to better address issues such as the interplay of physical and psychiatric care in the total health of the individual; the negative side effects of medication; and the reduction of morbidity and mortality for adults with mental illnesses. In discussing priorities for the FY 2012 State Plan, MHA leadership identified the importance of strategies providing for collaboration with consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the PMHS. This spring, MHA participated in a two-day Wellness and Smoking Cessation Policy Academy. The policy academy included key staff from MHA, ADAA, and DHMH’s public health programs as well as representatives of non-profit, consumer, and advocacy agencies.

TABLE 2 – PLAN YEAR 2012 - 2013:

State Priorities	
1	Recovery Supports – Wellness Recovery Action Plans/Employment Opportunities
2	Public Awareness and Education – Mental Health First Aid
3	Tobacco/Smoking Cessation
4	Workforce Development – Action Plan
5	Suicide Prevention
6	Co-Occurring Disorders – Promotion of Dual Diagnosis Capability/Training
7	Access to Services for Adults and Children
8	Evidence-Based Practices

DEVELOP OBJECTIVES, STRATEGIES AND PERFORMANCE INDICATORS

TABLE 3 - FY 2012 – FY 2013

PRIORITY AREA #1 - Recovery Supports – Wellness Recovery Action Plans/Employment Opportunities:

GOAL: Increase public awareness and support for improved health and wellness

STRATEGY 1: MHA, in collaboration with On Our Own of Maryland (OOOMD), will support statewide activities promoting the continuance of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement. **(Year 1)**

INDICATORS:

- Statewide wellness and recovery trainings for providers
- Continued implementation of WRAP training in local consumer peer support and advocacy organizations across Maryland such as Wellness and Recovery Centers
- Continued training of Olmstead Peer Support Specialists as an additional WRAP resource for hospital discharge planning.

STRATEGY 2: Expand intensive skills-based training opportunities to include motivational interviewing, person centered planning, and core concepts of recovery and resilience to increase the effectiveness of service delivery within the PMHS. **(Year 1 and Year 2)**

INDICATORS:

- Number of person centered planning trainings held for consumers and providers

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

- **STRATEGY 1:**
 - Work collaboratively with OOOMD and Wellness and Recovery Centers to increase recovery tools
 - Annual reports submitted to MHA Office of Consumer Affairs
 - MHA Office of Core Service Agencies (CSA) Liaison's Quarterly CSA Monitoring process
- **STRATEGY 2:**
 - Administrative Reports

PRIORITY AREA # 2 - Public Awareness and Education – Mental Health First Aid

GOAL: Increase public awareness and support for improved health and wellness

STRATEGY: MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Missouri Department of Health, and the National Council for Community Behavioral Health, will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland. ***(Year 1 and Year 2)***

INDICATORS:

- Continued publication, distribution, and promotion of Mental Health First Aid Participant Manual and Teaching Notes
- Work with Mental Health Association of Maryland, Inc. (MHAMD), national partners, and advocates to finalize a MHFA USA Youth Manual and teaching notes
- Web-based MHFA USA training developed to increase access and availability for the general public
- Revised suicide Webinar containing latest national and state data
- Curriculum supplements developed and piloted for workplace, law enforcement, military/veterans, primary care, assisted and aging living, faith communities, and higher education
- Partner with MHAMD and CSAs to deliver additional training to local Area Offices on Aging, Department of Social Services, law enforcement, parole and probation, judges, public health, EMS personnel, shelter workers, higher education, and state employees
- Continued use of fidelity evaluation for ongoing evaluation of MHFA instructors to insure they are maintaining fidelity to the curriculum

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

- Bi-annual reporting of MHFA activities (Mid-year reporting and final reporting)
- Collect data on number of persons trained in MHFA

PRIORITY AREA # 3 - Tobacco/Smoking Cessation

GOAL: Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span

STRATEGY 1: Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), ADAA, consumers, providers, private partnerships, and other behavioral health stakeholders to promote and implement the smoking cessation initiatives for all individuals served by the Public Mental Health System to reduce mortality rates. **(Year 1 and Year 2)**

INDICATORS:

- Number and percentage of adults (18-64) with SMI who are receiving outpatient mental health services in the PMHS and who have participated in the Outcomes Measurement System (OMS) at least two times.
- Guidance and technical assistance provided to CSAs on successful smoking cessation initiatives (such as two models implemented in Silver Spring Wellness and Recovery Center and Lower Shore Friends, Inc.)
- Increased awareness, promotion of public education, and raised consciousness of the essential role of smoking cessation in overall wellness through multiple media sources as well as shared information gained through the state's Outcome Measurement System survey; also, smoking cessation resources added to Network of Care (NOC)
- Collaboration with the MDQuit Center in the development of tools for ongoing evaluation of the effectiveness of smoking cessation efforts

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

- *SMART Data System (ADAA) and OMS data (MHA)*
- System integration of elements of coordination of care in PMHS through the Community Mental Health Medical Directors Consortium
- Utilization of results of SAMHSA Policy Academy for Maryland on Wellness and Smoking Cessation to develop and implement Statewide Plan in conjunction with the Alcohol and Drug Abuse Administration (ADAA), providers, CSAs, and consumers

PRIORITY AREA # 4 - Behavioral Workforce Development

GOAL: Provide coordinated approach to increase employment and promote integration of services and training to develop and sustain an effective behavioral health workforce.

STRATEGY 1: MHA, in collaboration with DHMH, ADAA, and DDA, will convene a workgroup to develop an action plan for behavioral health workforce development. **(Year 1)**

INDICATORS:

- Available infrastructure to support and coordinate workforce development evaluated
- Use of data to track, evaluate and manage key workforce issues
- Needs assessment conducted to determine workforce capacity
- Recruitment and Retention issues addressed

STRATEGY 2: The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue to promote the use of curricula for training of staff in child mental health professions based on established core competencies. **(Year 1 and Year 2)**

INDICATORS:

- Training modules marketed for undergraduate and graduate-prepared individuals to receive continuing education units (CEUs) via Web-based educational technology; number of individuals completing modules
- Mental health training modules/core competencies for educators developed to assist them in working with children, and their families, with mental health needs .

STRATEGY 3: MHA's Office of Special Needs Populations, in collaboration with ADAA, and DDA, will provide information and extend technical assistance through training and promotional materials to health agencies regarding the identification, education, and treatment of consumers with trauma histories. **(Year 1 and Year 2)**

INDICATORS:

- Identification of key screening and assessment tools of trauma, such as Screening, Brief Intervention, Referral, and Treatment (SBIRT) and the Adverse Childhood Experiences questionnaire, to be utilized as the standard tool for all practices across systems and agencies (emergency rooms, military, criminal justice, child-serving systems, etc.)
- Technical assistance, general public education, and social marketing (including consumers, general assembly, etc.) provided on trauma to ensure culturally competent, trauma-informed systems and better coordinated service systems (ex: pre-trial evaluation pilot)
- Identification of Evidence-Based Practices (EBPs) - science-informed practices with proven outcomes - and workforce enhancement needs to address identified gaps.
- Necessary regulatory changes determined and financing strategies developed including federal funding opportunities (grants, MA, health care reform) and cross-system duplication to fund gaps in trauma-focused intervention and treatment.

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

STRATEGY 1

- DHMH Workgroup convened

STRATEGY 2

- Training modules marketed for undergraduate and graduate–prepared individuals to receive continuing education units (CEUs) via Web-based educational technology; number of individuals completing modules

STRATEGY 3

- Screening, Brief Intervention, Referral, and Treatment (SBIRT) utilized
- Technical assistance, general public education, and social marketing (including consumers, general assembly, etc.) provided

PRIORITY AREA # 5 - Suicide Prevention

GOAL: Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span.

STRATEGY 1: MHA, in collaboration with Governor's Commission on Suicide Prevention, CSAs and other stakeholders, will continue efforts to address and implement suicide prevention/intervention/postvention activities for youth, adults, and older adults. **(Year 1)**

INDICATORS:

- Continued monitoring of utilization of Youth Suicide Hotlines for increased access
- DHMH/MHA participation in the Governor's Commission on Suicide Prevention and workgroups established to focus on issues of various populations.
- Interim Commission report submitted

STRATEGY 2: Recognize and address the special needs of returning veterans, LGBTQ youth and adults. **(Year 1 and Year 2)**

INDICATORS:

- Promote education and outreach activities to increase awareness and resources
- Continued monitoring of utilization of Youth Suicide Hotlines for increased access
- DHMH/MHA participation in the Governor's Commission on Suicide Prevention and workgroups established to focus on issues of various populations,

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

- **STRATEGY 1**
 - Recommendations from the Governor's Commission on Suicide Prevention workgroups
 - Plan developed for suicide prevention across the life span, strategies implemented
- **STRATEGY 2**
 - Annual Suicide Conference with inclusion of trainings/sessions on special needs populations
 - Information disseminated in schools, college campuses; utilization of the Suicide Prevention Resource Center

PRIORITY AREA # 6 - Co-Occurring Disorders – Promotion of Dual Diagnosis

Capability/Training

GOAL: Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span.

STRATEGY 1: In collaboration with DHMH, Continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment. **(Year 1)**

INDICATORS:

- Provision of training/coaching by the University of Maryland Evidence Based Practice Center's Consultant/Trainer on Co-Occurring Disorders
- Technical assistance (TA) provided to Core Service Agencies requesting assistance in promoting DDC within their jurisdictions
- Continued TA to the substance abuse specialists on Assertive Community Treatment (ACT) teams

STRATEGY 2: - Create a system of integrated promotion, prevention, and treatment options for children, youth, and young adults who are at risk for, or have mental health and/or substance abuse disorders that includes a strong focus on supporting their families and the communities where they live.

INDICATORS:

- The Institute of Medicine (IOM) prevention framework adopted
- ADAA prevention infrastructure further developed
- Policies, procedures and regulations reviewed across systems

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

STRATEGY 1

- Ongoing training provided on the use of scientifically-validated screening and assessment instruments in support of screening for and assessment of co-occurring disorders

STRATEGY 2

- Mental health and substance abuse systems professionals cross-trained in co-occurring treatment best practices with recipients of behavioral health services and their families

PRIORITY AREA # 7 - Access to Services for Adults and Children

GOAL: To maintain access to public mental health services for eligible individuals with mental illness.

STRATEGY 1: In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care.

INDICATORS:

- Contract requirements monitored
- Information shared with key stakeholders
- Analysis of utilization management practices

STRATEGY 2: In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 210 children and youth and their families. **(Year 1)**

INDICATORS:

- Number of Waiver providers enrolled, (including youth and family peer support providers)
- Number of youth enrolled
- Ongoing Implementation of waiver quality assurance plan

STRATEGY 3: Draft a 1915(i) to sustain the Residential Treatment Center (RTC) Waiver for children and adolescents. **(Year 2)**

INDICATORS:

- Draft completed, reviewed and submitted for CMS approval
- Eligibility criteria, services and payment rates developed.
- Regulations developed

STRATEGY 4 - Implement the provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches. **(Year 1 and Year 2)**

INDICATORS:

- A consistent model for family peer support established
- Financing approach identified for populations served by CMEs
- Expansion of population eligibility served by CMEs explored
- A crisis response and stabilization model identified
- Coordination of CME service recipients' somatic and oral health improved consistent with wellness and Early and Periodic Screening Diagnosis and Training (EPSDT) standards of care
- Completion of program planning tool

STRATEGY 5: In collaboration with Maryland Medicaid, review and amend Maryland's State Medicaid Plan to include community mental health services; once revised submit amendments for approval to the Centers for Medicare and Medicaid Services (CMS).

INDICATORS:

- Service descriptions, curricula and certification processes (where applicable), refined and/or developed
- Professional qualifications for psychiatric rehabilitation programs (PRPs), supported employment, peer support, and residential and mobile crisis services refined and/or developed
- A 1915(i) state plan amendment drafted to include PRP and supported employment as Medicaid-reimbursable services; peer support and crisis services submitted separately to accommodate further regulatory development

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

STRATEGY 1

- Monthly and quarterly reports generated by ASO; analysis of reports by involved parties
- Analysis of PMHS utilization data and management practices

STRATEGY 2

- A running log of enrolled providers is maintained – tracking them from initial interest through assignment of MA number.
- Youth enrollment roster is updated weekly.
- The waiver quality assurance plan requires a number of data elements from multiple sources to be compiled and submitted to CMS annually.

STRATEGY 3

- Documents for application are maintained.
- Regulations promulgated through established process.

STRATEGY 4

- A CHIPRA Project Management tool collects data on all indicators and is part of the national evaluation

STRATEGY 5:

- The 1915(i) state plan amendment refined and submitted to the Centers for Medicare and Medicaid Services (CMS).

GOAL: Work collaboratively to reduce the impact of violence and trauma for individuals with serious mental illness and other special needs

STRATEGY: Continue to monitor crisis response systems, diversion activities, and community aftercare services to increase the diversion of inpatient and detention center utilization by individuals with mental illnesses. **(Year 1 and Year 2)**

INDICATORS:

- Stakeholder workgroups convened to refine service descriptions, curricula, certification processes (where applicable), and professional qualifications in regulations of residential and mobile crisis (as well as peer support and supported employment services)
- Workgroup recommendations used in working with Maryland Medicaid to make above services eligible for federal payment
- Number of uninsured individuals diverted from emergency departments, MHA facilities, other inpatient services, and detention centers
- Number of alternative services provided

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

- Reduction of emergency department requests for admission to state hospitals
- Service continuum plan developed

PRIORITY AREA # 8 - Evidence-Based Practices

GOAL: Utilize data and health information technology to evaluate, monitor, and improve the quality of PMHS services and outcomes

STRATEGY 1: Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education. **(Year 1 and Year 2)**

INDICATORS:

- Annual evaluations of programs to determine eligibility for EBP rates
- Increased number of programs meeting fidelity standards for EBP programs
- Number of new programs established

STRATEGY 2: MHA, in conjunction with the University of Maryland Systems Evaluation Center (SEC), will aggregate, cross-match, and triangulate data from multiple data sources related to the implementation of supported employment (SE) to ensure the integrity and accuracy of data as a means to promote systems integration and to further inform data-driven, interagency policy development and program planning. **(Year 1 and Year 2)**

INDICATORS:

- Supported Employment claims and Division of Rehabilitation Services (DORS) data analyzed; Evidence-Based Practice provider reports completed
- Report submitted by SEC
- Information disseminated to provider community
- Strategies developed, findings incorporated into future planning

DESCRIPTION OF COLLECTION AND MEASURING CHANGES IN PERFORMANCE INDICATORS:

STRATEGY 1:

- Annual evaluations of programs to determine eligibility for EBP rates
- Ongoing data collection on EBPs receiving training, meeting fidelity, and providing consumer services

STRATEGY 2:

- PMHS Claims Data Reports on SE
- DORS 911 Data (federally standardized data report)
- Dartmouth Johnson and Johnson Outcomes Data Reports
- EBP Provider Reports

Section III – Narrative Plan

ACTIVITIES THAT SUPPORT INDIVIDUALS IN DIRECTING SERVICES

MHA promotes a comprehensive, community-based public mental health system focused on consumer recovery which employs evidence-based and effective practices and is outcome driven. MHA supports a consumer-centered system which offers a range of effective peer support services and promotes consumer-defined recovery and self-direction. The system offers choices and encourages movement towards independence, as identified by the consumer. Additionally, efforts to promote cultural competence and meet the needs of an increasingly diverse population are a critical component of the system and are an integral part of all initiatives, trainings, and programs.

MHA and the Mental Health Transformation Office (MHTO) implemented a consumer self-directed care pilot program in Washington County managed through the local Office of Consumer Advocates. The Self-Directed Care (SDC) program currently has 48 self-directed care plans developed and approved with two full-time and one part-time Peer Advocates assisting consumers with the process. Peer Advocates help consumers develop and implement their own “recovery plans”, which include “directing the use of their benefits to access both public mental health services and non-traditional support services. If needed, SDC consumer funds pay for non-traditional resources such as classes, project-related clothing, textbooks, etc. Several consumers are in college and on the Dean’s list. Additionally, individuals in the SDC program learn to independently manage their personal finances and are in various stages of developing or applying a plan for financial stability. To date WRAP training continues to be an integral part of the training the Peer Advocates and consumer participants receive with an emphasis on stress reduction and wellness. There is also a male advocate who addresses the unique needs of the men in the program. The current program now serves consumers in the evenings, on weekends, and in the home to accommodate the need for them to keep timely appointments. The use of the Network of Care is encouraged and fostered in the Wellness Center as well as in the community settings.

MHA, in collaboration with the CSAs has supported On Our Own of Maryland’s (OOOMD) initiative to transform its consumer network toward a wellness and recovery-oriented system. With the implementation of Wellness and Recovery Action Plans (WRAP), enhanced peer support activities and the use of best practices within the community have evolved. WRAP training has been instituted in the peer specialists training module developed by the Maryland Association of Peer Support Specialists and WRAP is incorporated into all consumer-run Wellness and Recovery Centers as a model for peer support. Peer advocates and participants in the SDC have also received the WRAP training with an emphasis on stress reduction and wellness. WRAP founder, Mary Ellen Copeland, visited a Wellness & Recovery Center in August 2010 and attended as a special guest at the Own Our Own of Maryland Annual Meeting in October 2010. In FY 2011, three advanced level WRAP facilitators were trained in the Copeland Model for WRAP. More than 2,700 people have participated in the WRAP introduction/orientation training. The trainings are successful in engaging consumers and assisting providers in planning for mental health recovery. Maryland now has over 90 WRAP

facilitators trained in a three-year period. A new WRAP Coordinator has been hired for FY 2012 to continue the guidance of this model program. WRAP is transformational in that it supports consumer-driven care and has helped change the way providers of mental health services think about recovery.

Person centered planning is designed to enable people to direct their own plan for services and supports. In concert with MHA's emphasis on a recovery-oriented and person-centered system of care, the MHA Office of Adult Services featured person-centered care at its annual conference in FY 2010 and decided to adopt a train-the-trainer approach. As a result, a national expert provided consultation, technical assistance, and two train-the-trainer sessions to a core group of 10 peer support specialists/peer advocates, Evidence-based Practice Center (EBPC) trainers, and several providers/staff in specialty areas such as; evidence-based practices, Traumatic Brain Injury waiver, co-occurring including mental health with developmental disabilities or with substance abuse, and aging (20 participants all together). The Peer Support Specialists work with consumers on ACT teams to prepare them to be active participants in their treatment planning processes. The EBPC trainers incorporate person centered planning training as part of their training activities among agencies. Director of the MHA Office of Consumer Affairs coordinates training with the consumer trainers selected from the ACT teams. As a vehicle for training and disseminating person centered planning concepts, the EBPC worked with supported employment programs and ACT teams to set up a Supervisors Collaborative for each discipline. The Collaborative meet bi-monthly to introduce person-centered planning, determine its impact on practice and documentation, and to effectively utilize this approach to supervise staff. Additionally, ASO staff is being trained on the implications of utilization review and medical necessity determination within a person centered planning framework. Further trainings from the consultant to the master trainers and Peer Support Specialists on ACT teams will be offered in the coming year.

The Consumer Quality Team (CQT) initiative, now entering its fourth year, allows consumers and family members to play a direct role in the improvement of mental health services by recording and addressing individual consumers' satisfaction with the services received. CQT is transformative as it is the one of the first projects with an emphasis on meaningful involvement of consumers and families in evaluation activities. This is also the first project where the evaluation is consumer-operated. The project also protects and enhances rights by obtaining first hand information from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. Both consumers and program staff have reported significant program changes made as a result of the reports. This project is discussed further in Evaluation Services.

DATA AND INFORMATION TECHNOLOGY

The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). On September 1, 2009, a new vendor, Value Options Inc. was selected to contract as the new ASO for the Public Mental Health System (PMHS). Historical data from the previous vendor was transferred to ValueOptions. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on client's service authorization and events as well as the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Over 4,000 mental health care providers comprise the Maryland PMHS Provider network. Each Medicaid approved provider is linked through a National Provider Identifier (NPI). No Medicaid claim can be processed through the claims system without an NPI. Individuals served through the PMHS are also assigned a unique client identification to identify them within the claims system. This unique identification allows for induplication across service categories and funding types. Finally, event and cost data are derived from claims files.

The ASO is contracted to support mental health services access, utilization review, and care coordination tasks. The ASO data system complies with all Federal data standards. The PMHS data are collected and displayed by demographic, clinical service, provider and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PMHS data system, through a series of interrelated databases and software routines, can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals
- provider claims audit, providers by jurisdiction
- services utilized by level of care and service
- treatment service lengths and number of units provided
- site visits, including record reviews and second opinion (peer) reviews of authorization
- provider pharmacy utilization and data reports, pharmacy data alerts

Implemented in July 2007, information on Medicaid drug prescriptions filled by consumers in the PMHS is available through the ASO. These prescriptions are for all medications other than HIV medications, regardless of prescriber. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy data is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to managed care organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts.

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The ASO Management Information System (MIS) does not capture data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represent an undercount, most noted within the elderly population.

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2012 State Plan, MHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

The MHA submitted its application to SAMHSA/CMHS for a fourth round of the Data Infrastructure Grant in June 2010. The required Basic and Developmental Tables were submitted in December 2010. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS) which are within the ASO system. Some data, such as employment status and residential status along with detailed racial and ethnicity data are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Satisfaction and Outcomes Survey for many National Outcome Measures (NOMs), though the newly implemented Outcomes Measurement System (OMS) may allow MHA to move to client level reporting for some of these measures. Data from state operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS) and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables.

This identifier has been used to link data from the two systems. Data for those tables reporting on individuals served and services provided are collected and reported at the person level.

To strengthen Maryland's services and data system, Deputy Secretary Renata Henry has mediated the development of a data workgroup comprised of key MIS staff of the three behavioral health administrations, Mental Health, Developmental Disabilities and Alcohol/Drug Abuse. Referred to as the Behavioral Health Data workgroup efforts have been implemented to begin the process of data system integration. Strategies will be developed to identify and track those users across administrations. A goal of the Behavioral Health Data workgroup is to promote data sharing relationships with other state agencies.

Additionally, through Maryland's State Stat, MHA is also responsible for providing information on agency performance and priority initiatives. State Stat is a performance measurement and management tool implemented by the Governor to make our state government more accountable and more efficient. October 2011 will see a new version of the Governor's State Stat with emphasis on performance and outcome measures.

QUALITY IMPROVEMENT REPORTING

Several major Evaluation Services endeavors are discussed in this section, including MHA's Outcomes Measurement System (OMS); the Consumer Quality Team (CQT), which is funded in large part through this MHBG; the annual Consumer Perception of Care Survey (CPOC); and evaluation projects and activities conducted through MHA's contract with the University of Maryland Systems Evaluation Center (SEC), which is also funded through this MHBG.

The Consumer Quality Team (CQT) initiative, funded in large part through this block grant and launched in FY 2007 through the Maryland Mental Health Association, was another significant evaluation project that was continued in FY 2011. During FY 2011, the CQT conducted 282 site visits to Psychiatric Rehabilitation Programs (PRPs) and inpatient facilities, interviewing approximately 1,112 consumers. The purpose of the interviews is to identify and address specific concerns of individual consumers. At the conclusion of all interviews within a program or facility, the team gives a brief verbal report to the program director or CEO of the facility, resulting in the immediate resolution of many of the identified individual concerns. Monthly feedback meetings regarding the PRP visits are also held with representatives from the appropriate local Core Service Agencies, provider organizations, and MHA. In addition, the leadership staff of CQT meets with the senior management staff of MHA on a quarterly basis to discuss the overall project, issues, trends, etc. While there will be no additional expansion of the CQT project in FY 2012 (due to fiscal constraints), the ultimate goal is offer this initiative in all 24 jurisdictions and the remaining State-operated facilities.

In addition to the above routine activities, CQT continued the project to track the 63 consumers who were discharged as a result of the closure of the Upper Shore Hospital Center. Approximately 44 of the 63 individuals were interviewed either in-person or by phone, and CQT is working with MHA and the appropriate CSAs to locate and interview the remaining individuals. As a result of this project, CQT expanded its activities into six programs in several jurisdictions on the Eastern Shore.

Other major activities of the CQT in FY 2011 included:

- 1) Sharing lessons learned and findings of the Consumer Quality Team at national and local mental health conferences, including:
 - a. "Turning Up the Volume of the Consumer Voice: Building the Consumer Quality Team of Maryland" – 75 minute workshop at Alternatives 2010: Promoting Wellness Through Social Justices annual conference in Anaheim, CA in September 2010.
 - b. "The Consumer Quality Team: a Path Towards Recovery" – 75 minute presentation at NAMI Maryland Annual Education Conference in Baltimore, MD in November 2010.
- 2) Ensuring that the consumer's perspective is represented by serving on the following committees:
 - a. Leadership Council, Recovery Centers of Excellence Project, Community Psychiatry Program, Johns Hopkins Bayview Medical Center

- b. Consumer Advisory Committee, Workforce Development Initiative, The Sar Levitan Center, Institute for Policy Studies, Johns Hopkins University
- c. MHA Facilities Recovery Work Group
- d. Maryland Consumer Leadership Council
- e. Maryland Association of Peer Support Specialists
- f. Behavioral Health Services Network, Eastern Shore

In working with these committees, CQT has been instrumental in the development of the Peer Employment Specialist Toolkit and the curriculum for the Maryland Peer Support Specialist Certification Program.

MHA's Office of Compliance and the ASO complete audits for provider, inpatient, and outpatient programs each year. Provider services included psychiatric rehabilitation programs (PRPs), outpatient mental health clinics, residential treatment centers, and hospitals. In all instances, audit findings are presented in a formal report and, as required, corrective actions are identified and implemented through an approved Performance Improvement Plan. Additionally, retrospective reviews of hospital stays are completed through chart audits. MHA's Office of Compliance continues to work with the Office of the Inspector General to prevent fraud and abuse.

In addition to the two major evaluation initiatives described above, MHA, through its contract with the ASO, continues to conduct annual Consumer Perception of Care (CPOC) surveys via telephone interviews. As with previous survey efforts, the survey tools are based on the most recent versions of the Mental Health Statistics Improvement Project (MHSIP) consumer survey tools for both adults and children and adolescents and their families. The CPOC surveys were conducted in Winter/Spring 2010 with individuals who received outpatient mental health services in 2009 and the analyses of results were completed. An Executive Summary Report and tri-fold pamphlets detailing the results of the survey were prepared and widely disseminated. In order to continue to comply with annual federal URS requirements, the CPOC surveys were conducted again in the third quarter of FY 2011. Analyses of the current survey results will be completed in FY 2012, and reports and tri-fold brochures will again be generated and distributed. (Information from the CPOC surveys is used to address several MHBG indicators).

Finally, MHA continued to contract during FY 2011 with the Systems Evaluation Center (SEC) within the University of Maryland, School of Medicine, Department of Psychiatry, Center for Mental Health Services Research, Mental Health Systems Improvement Collaborative (MHSIC) for a variety of PMHS evaluation projects and activities. This Center is funded through this block grant. The SEC, now in its tenth year of operation, began its work in August 2001 (FY 2002), and is one of three centers within the MHSIC. The others are the Training Center and the Evidence-Based Practice (EBP) Center. The SEC was created to increase MHA's capacity for a methodical and systematic approach to measuring PMHS performance. Overall goals of the SEC are to design systems/program evaluation questions, methods, and studies; develop analytic structures for more advanced analysis of existing PMHS data; and identify cost-effective practices with positive outcomes for consumers. In doing so, MHA obtains

information that enhances its ability to plan, manage, monitor, and evaluate PMHS efficiency and effectiveness.

Highlights of SEC projects and activities during FY 2011 included:

- participating in the OMS Datamart development activities, including: 1) finalizing the analytical structures needed for producing “change-over-time” outcome analyses; 2) producing various documents, including crosswalks, analysis specifications, nomenclature rules, and display requirements needed by the ASO for its development of functional specifications; and 3) participating in collaborative meetings and detailed review of the functional design specifications required to implement the OMS Datamart project.
- continuing implementation of the OMS Validation Study data collection and analyses;
- continuing to provide consultation regarding evaluation-related issues to the CQT initiative;
- providing technical assistance and support related to the evaluation of evidence-based practices and an outcomes benchmarking project;
- conducting evaluation activities related to integration of somatic and mental health service provision (e.g., analysis of health status, smoking, and Body Mass Index (BMI) for adults);
- continuing to implement the Data Infrastructure Project (DIP)/PMHS Data Analysis Project, including assisting MHA to complete all basic and developmental Uniform Reporting System (URS) tables; working with other MHA contractors and the ASO on a variety of ASO data-related issues; providing technical assistance and consultation to MHA and the ASO in the areas of rates, Medical Assistance/Medicaid Management Information Systems (MMIS), client-level reporting, employment analyses, OMS, CPOC surveys, and URS issues; providing analysis for an economic evaluation of the Self-Directed Care initiative; and providing analyses of PMHS data in support of many other CSA and MHA projects;
- engaging in activities related to SEC capacity building, including participation in the preparation of grant application and delivering presentations related to SEC activities; and
- continuing to provide supervision, support, technical assistance, and consultation needed to finalize/complete all activities related to the evaluation component of the Mental Health Transformation State Incentive Grant (MHT-SIG), including providing supervision for all MHT-SIG evaluation activities; performing management and administrative functions for the MHT-SIG contract; and completing implementation of the federally required national evaluation Proof of Concept recovery and resilience studies and local evaluation activities (It is anticipated that all MHT-SIG-related activities will be finalized and completed by the end of CY 2011.)

SUICIDE PREVENTION

Suicide trends in Maryland: Suicide among youth, adult and older adult populations is a public health issue that requires an immediate in-depth examination of causation and prevention strategies. From 1990 – 2006 there were 1,219 completed suicides by Maryland youths, as compared to 1,520 documented suicide deaths from 1970 – 1985. Maryland youth suicide rate follows the national trend, but there are geographic regions of Maryland with higher youth suicide rates. Linkages to Life: the Maryland State Plan for Suicide Prevention: FY 2008-2012 was developed to improve public awareness of youth and young adult suicide and the availability of resources. The plan promotes strategies to help decrease suicide; overcome stigma; ensure delivery of prevention, intervention and postvention approaches; and provide programs in a culturally competent manner.

Also the Maryland Vital Statistics Administration reports that in 2008 there were 492 deaths in Maryland attributed to “intentional self-harm,” or suicide. Of this number, 471 suicides were within the adult and older adult populations. In the first eight years of this decade (2000-2007) there was an average of five suicide completions in Maryland every four days. The Governor’s Office and the legislators expressed deep concern regarding the prevalence of suicide among Maryland’s adult and older adult populations.

In October 2009, Maryland’s Governor O’Malley signed an Executive Order to create a Maryland Commission on Suicide Prevention. The 21-member commission is comprised of members from various state departments, the Legislature and advocacy organizations along with a family member of an individual who completed suicide and a suicide survivor. The Commission is charged with the development of a comprehensive, coordinated, strategic plan for suicide prevention, intervention, and post-vention services across the state.

Additionally, in the spring of 2009, the Maryland Mental Hygiene Administration convened a committee to discuss suicide prevention across the life span. The committee developed a position paper that presented an overall picture of how the Public Mental Health System could collectively improve and fund prevention and post-intervention efforts that support populations at risk and develop an all-inclusive strategic plan identifying recommendations for consideration by the Governor’s office for the citizens of Maryland. To this end, the committee reviewed several significant documents and reports addressing suicide in the adult and older adult populations, including reports from the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse Mental Health Services Administration (SAMHSA) for guidance in the formulation of strategies to successfully address Maryland’s concerns, as well as research into causation and prevention strategies.

CURRENT SERVICES - STRENGTHS:

Pockets of excellent services and crisis response systems exist in selected areas of Maryland. Some of the services include:

- 24 Hour crisis/warm/hot lines
- Mobile crisis programs with a variety of models
- Comprehensive crisis services such as In Home Intervention Teams, Urgent Care, Hospital Diversion and Crisis Beds
- Yellow Ribbon Suicide Prevention Campaign
- Local Health Department/Core Service Agency public broadcasts
- Outreach and Training

The committee paid special attention to “hotlines” in use throughout the state and sees the importance in exploring the option of combining all existing hot lines into one central hotline number throughout the State.

CURRENT SERVICES - GAPS:

While there are pockets of excellent services and crisis response systems throughout the state, currently no comprehensive, integrated approach exists to address adult suicide prevention or successful interventions in Maryland. This is due in part to the dearth of qualified mental health practitioners in many parts of the state. Seven Maryland areas have crisis teams, while 17 do not. This is particularly evident outside of the Baltimore metropolitan area, especially in the western, eastern and southern regions of the state.

The committee recommended that the Governor convene a Statewide group of stakeholders to further define recommendations, prioritize issues and address financial concerns. Other recommendations include:

- Governance and oversight
- Education and training
- Public awareness and advocacy
- Systems coordination and development; and
- Technology, data collection and research

Recently, the Commission divided into three Workgroups, to focus on three areas: Public Awareness, Prevention/ Intervention, and Post-vention. Strategies suggested in the original two documents (Youth Suicide Prevention (2008) and MHA's position paper on Suicide prevention for the Adult and Older Adult Populations (2009) were cross-walked, combined (where applicable) and sorted into these three areas. Also, strategies might be specified to a special high-risk population(s) such as veterans or LGBTQ. Each Workgroup is charged with discussing overarching strategies that:

- Advance the science of suicide prevention
 - Test, replicate and utilize new strategies (promising and evidence-based practice pilot sites) as appropriate throughout the State
- Support MHA's Mission and Values statements that reflect concern for all persons with mental illness of all ages, supporting a consumers' right to access appropriate mental health services in all suicide prevention, intervention and post-vention efforts, and
- Develop more coordinated prevention, intervention, and post-vention services across the state for all ages.

INVOLVEMENT OF INDIVIDUALS AND FAMILIES

Partners in Recovery and Resilience -The strength of Maryland's PMHS comes mainly from its long-time collaboration with consumer, family, advocacy, and provider organizations. MHA has partnered with these organizations since their inception and, in fact, fostered their development. Additionally, MHA's partnerships include academic institutions and federal, state, and local agencies.

Youth & Family Involvement - The value placed on youth and family member participation continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2010, MHA will continue to fund the Maryland Coalition of Families (MCF) for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities. The Coalition's mission is to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system.

A highly successful project of MCF, jointly with the Maryland Mental Health Association, is the "Children's Mental Health Matters" public awareness campaign. This project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. The campaign is a partnership with local broadcast affiliates and involves Maryland's First Lady, Katie O'Malley, as Honorary Chair and Debbie Phelps, mother of Maryland's celebrated Olympic swimmer, Michael Phelps, as media spokeswoman. A major media blitz occurred during Children's Mental Health Week during this past May and will be continued in the upcoming year.
(www.childrensmentalhealthmatters.org).

MCF has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past year's plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In addition, in FY 2004, MCF established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in becoming advocates in their communities and the state. The fifth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the five years of the Institute's implementation.

Maryland maintains an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. In conjunction with its commitment to system transformation, MHA maintains a focus on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency. The MHA Office of Consumer Affairs (OCA) participates in systems level activities at all pertinent MHA meetings. MHA, in collaboration with the Maryland Mental Health Transformation Office (MHTO), has made a number of significant investments in promoting consumer-driven care through several specific programs/initiatives.

MHA and the local CSAs have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. MHA, in collaboration with the CSAs has supported On Our Own of Maryland's (OOOMD) initiatives to transform its consumer network toward a wellness and recovery-oriented system and to enhance peer support activities and the use of best practices within the community. These collaborations include:

- Recovery Training Project (formerly the Advocacy Training Project) which provides training to adult psychiatric rehabilitation programs (PRPs), outpatient mental health clinics (OMHCs), and consumer groups as a step in a longer term effort to assist Maryland's Public Mental Health System (PMHS) to begin or continue to incorporate practices based on recovery into their agencies. Three Workshops have been developed within this project to include 1) "Motivational Vitamins" provides information to help participants to work through common hesitations about entering or re-entering the workforce; 2) Discovering your Recovery Muse, which approaches recovery from a non-traditional angle introduces participants to better health through various creative processes such as art, dance, music, and writing; and 3) Steps to a Healthier You designed to motivate and inspire participants to make smarter choices about nutrition, increase physical activity, and develop helpful habits.
- MHA also, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also WRAP facilitators, facilitate consumer discharges and provide ongoing support during the consumers' transition into the community from three state facilities: Springfield, Eastern Shore, and Finan Hospital Centers. In FY 2011 a total of 111 consumers in state hospitals were seen by the PSS staff. PSS staff also provided help and referrals to Wellness & Recovery centers (22 of the 25 Centers are OOOMD affiliates), CSAs, and other organizations that work to enhance recovery.
- OOOMD and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP) which helps participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, and the reduction/elimination of seclusion and restraint and are presented in a wide spectrum of venues, such as local Wellness & Recovery centers, housing authorities, homeless shelters, and statewide conferences and universities. In FY 2011, the ASP presented 51 workshops throughout the state which trained 1,112 people in the full program and reached at least 259

additional participants on various levels. OOOMD continues to receive requests for the teaching videotape, "Stigma...In Our Work, In Our Lives", which is now being used in more than 39 states and four other countries. A new workshop has been added on internalized stigma, "An Inside Look at Stigma," as well as a workshop on creating non-stigmatizing environments. ASP is currently using resources from the MHT-SIG to collaborate with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool.

Maryland provides support to the statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. MHA worked successfully with NAMI MD in promoting the NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. In 2011, the annual NAMIWALKS, that takes place on the first Sunday each May, was expanded to include two major walks; one in Baltimore City and one in Montgomery County. NAMI MD has developed a strong Family-to-Family Education presence in the state. The "In Our Own Voice" program is an informational outreach program on recovery. Peer-to-Peer is a unique, experiential learning program for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. With support from MHTO, NAMI MD has begun two initiatives to support the integration of physical and mental health – NAMI MD's Healthy Hearts and Minds education program and an information dissemination project. Additionally, NAMI MD presents an annual education conference for families, consumers, and providers. In FY 2011 MHA will continue to support NAMI MD's public education and training efforts. Maryland's strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PMHS.

The Maryland Consumer Leadership Coalition (MCLC) was created by MHA's Office of Consumer Affairs (OCA) in FY 2008. The MCLC is comprised of leaders in the consumer movement from diverse cultural and organizational backgrounds who work as mental health advocates at the state and national level. This group focuses on system improvements and effective consumer advocacy. Its long-term goals include facilitating leadership and involvement of consumers in their mental health treatment in every jurisdiction, and preparing them for the responsibility of partnering with mental health professionals and administrators in shaping the mental health system in Maryland. They consider themselves the think-tank of the Maryland consumer movement.

The work of MCLC continues to enhance the incorporation of peers into the workforce through Peer Employment Resource Specialist (PERS) Training. To date there have been 86 PERS consumer graduates throughout the state. In the summer of FY 2012 follow-up PERS training sessions will be specifically for PERS Graduates. Both of these training sessions will be held at the Johns Hopkins University, Homewood Campus in Baltimore City and will cover two different topics:

- **Employability Development Planning:** This session will provide the trainees with information and tools to assist them to work with consumers who want to develop a career action plan that articulates the steps needed to make the plan happen and to successfully start on the pathway for career success.

- Job Development – How to Engage Employers: This session is for staff who want to hone their job development skills and gain insights as to how to better work with employers to gain job opportunities for consumers.

The OCA, with funding from the MHT-SIG is developing and creating a recovery/success stories and training DVD that will highlight and enhance the consumer programs funded by MHA such as: WRAP, PERS, Consumer Quality Team, Supported Employment, Bridge Subsidy Program, Self Directed Care and person centered planning. The purpose of the recovery stories training DVD is to educate, highlight and train consumers, family members, and the general public and other stakeholders. The recovery stories training DVD will be designed to showcase and enhance consumer recovery from serious mental illness and that recovery is possible across the life span. This is a unique window of opportunity to educate and create real change in breaking down attitudinal behaviors and eradicating stigma.

USE OF TECHNOLOGY

Network of Care - The PMHS continues to improve access to services through innovative projects. Using technology to improve access to mental health services, MHA has maintained a Web-based resource site, Network of Care (NOC) for Behavioral Health, which provides local, state, and national information to help consumers and families access services and manage their mental illness. Specialized service information is provided for Maryland's Youth as well as Veterans and Families. The site contains a listing of services; a library of mental health articles; a list of support and advocacy organizations; legislation; and a personal folder/advance directive/Wellness Recovery Action Plan (WRAP) feature. Consumers have received training in the utilization of personal health record features, and in the use of individual advance directives. The goal is to provide simple and fast access to information for persons with mental illnesses, caregivers, and service providers. Core Service Agencies have been encouraged to support, at the county level, the expansion of and promotion efforts of Network of Care. In FY 2011 The Maryland Network of Care for Behavioral Health has recorded 992,662. (www.maryland.networkofcare.org).

In 2009 Maryland became the first state in the country to add a comprehensive veterans' portal to the state's Network of Care site. This unique initiative helps service men and women with behavioral health needs obtain access to services and manage their mental illness. A comprehensive Veterans was launched portal to help service men and women returning from Iraq and Afghanistan with behavioral issues obtain access to services. In response to the increasing numbers of returning veterans, Maryland was the first state in the country to launch the Network of Care for Veterans & Service Members. This site, kicked off by Lieutenant Governor Anthony Brown on March 31, 2009, is a one-stop-shop arrangement, bringing together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large. This public service is an attempt to bring together critical information for all components of the veterans' community, including veterans', family members, active duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large. The veterans' portal recorded over 135,000 sessions from its launch in March through June 2011.

Telemedicine - Another example of use of technology is telemental health services. Since November 2008, through grants, the Mental Hygiene Administration and the University of Maryland's Department of Psychiatry has partnered with three Core Service Agencies (CSAs) to provide psychiatric care in seven rural counties in the state. This tele-psychiatry program allows individuals living in rural areas to see a psychiatrist in Baltimore without traveling from their home communities. Clinical services began in December 2008.

In June 2011, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid State Plan Amendment (SPA) that allows distant site psychiatrists to be reimbursed for a psychiatric diagnostic interview, psychotherapy, and medication management. Telemedicine will be used to provide services to those individuals in the rural Western and Eastern Shore counties.

Health Information Exchange (HIE) and Electronic Health Records (EHR) - Maryland currently received grant funds to support HIE efforts through the Chesapeake Regional Information System for our Patients (CRISP). CRISP is Maryland's statewide Regional Extension Center (REC) which offers technical, implementation, and education assistance to facilitate providers' adoption and meaningful use of electronic medical records (EMRs). The mission and charge of CRISP and MHA is to enable Maryland's healthcare community to appropriately and securely share data, facilitate and integrate care, and improve outcomes. MHA, along with the State Alcohol and Drug Abuse Administration, is part of these efforts and sits on an Executive level board regarding the state adoption of an EHR. Currently the ADAA and its' providers use a WITS system known as SMART in the state. The potential to expand SMART to all mental health providers as an EHR option is in the exploration process. While this process continues, the Department has agreed to provide training regarding EHR adoption and meaningful use to its provider community.

Social Media - MHA has also initiated a Social Media campaign utilized to promote public mental health awareness and improved communication among MHA, CSAs, providers, advocates, consumers, and family members. Continued exploration of appropriate social media outlets, both relevant and socially important, to bolster Child and Adolescent initiatives and/or to provide Peer-to-Peer support will be conducted by MHA.

SUPPORT OF STATE PARTNERS

Collaborations with Other State Agencies - MHA continues to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance abuse, and other services and community supports. The development of the State Mental Health Plan is a result of the collaborative efforts related to the implementation of the federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. Alliances have been strengthened and new partnerships have been formed to further build upon the infrastructure, to coordinate care, and improve service systems. Collaborations with other State agencies include, but is not limited to: Maryland Department of Disabilities, Governor's Office for Children, Maryland State Department of Education, Department of Juvenile Services, Department of Human Resources, Department of Public Safety and Correction Services, Alcohol and Drug Abuse Administration, Developmental Disabilities Administration, Department of Housing and Community Development, Department of Rehabilitation Services, Office of the Deaf and Hard of Hearing, Maryland National Guard and Department of Veterans Affairs.

A chart of State Partners and MHA Liaisons are appended.

STATE ADVISORY COUNCIL

The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, often referred to as the Joint Council, is composed of consumers, family members of persons with psychiatric disabilities, mental health professionals, representatives of other state agencies, and other interested citizens and is an important source of advice and advocacy in Maryland. This includes a representative of the Alcohol and Drug Abuse Administration who has been instrumental in the co-implementation of some of MHA's initiatives for co-occurring issues such as the Supervisors' Academy for Co-occurring Disorders. This member also participates in workgroups that address common areas between the mental health and substance abuse administrations such as the Behavioral Health Data Workgroup.

The Joint Council continues its active involvement in MHA's planning process through its participation in the development of the State Mental Health Plan and the Federal Mental Health Block Grant Application. The Planning Committee is now monitoring public mental health system data and participating in the planning process year round. In 2011, a series of Planning Committee meetings were held to develop and review these key documents:

- The Planning Committee, which meets as needed after the full Council meeting, discussed priorities and prepared for the MHA public meeting on April 29, 2011 to develop the State Mental Health Plan. This year the meeting included broader participation of representatives in the area of behavioral health and substance abuse. More than 75 representatives of mental health advocacy organizations, wellness and recovery centers, Core Service Agencies (CSAs), local mental health advisory committees, representatives from the Alcohol and Drug Abuse Administration (ADAA) and members of the MHA Management Committee attended. The meeting was formatted to include six breakout groups with each focused on one of six goal areas in the State Mental Health Plan based upon the SAMHSA *Strategic Initiatives* to develop strategy concepts for the 2012 Plan.
- The Planning Committee of the Joint Council met on June 21st to review a draft of the Goals, Objectives, and Strategies for the FY 2012 Plan and modified, expanded, and strengthened the strategies as appropriate.

On July 19th, the full Maryland Advisory Council on Mental Hygiene/ PL 102 – 321 Planning Council received the report of the Planning Committee members and recommended the adoption of the FY 2012 State Mental Health Plan along with the following comments:

- Continue to support school-based mental health efforts.
- Address the need to further reduce the impact of homelessness. At the same time, the Council continues to encourage and support interagency efforts to promote a range of housing and residential options in Maryland. The availability of affordable housing remains a particularly critical need for consumer independence and recovery.
- Continue the partnerships with state and local entities with increased input such as trend analysis and examination of needs assessments from local entities into the statewide planning process.
- Continue to include child and adolescent advocacy groups for strategies that impact populations across the lifespan.
- Continue to focus attention toward workforce development needs including recognition of gaps in the workforce that provides services to the mental health and substance abuse (co-occurring) treatment population.
- Promote efforts toward wellness and prevention issues such as smoking cessation. We support MHA's focus on smoking cessation as a key response to disparities in mortality rates for people with mental illness.
- Continue to advance efforts to address co-occurring issues and service needs the Planning Committee observed that MHA successfully revised the State Plan Goals to incorporate SAMHSA's *Eight Strategic Initiatives* which includes areas of co-occurring and wellness across the lifespan.
- Follow closely the partnership of the mental health and the substance abuse administrations on levels of data, function, and policy.

On July 26th the Planning Committee held an additional meeting to review key sections of the FY 2012 Federal Block Grant Application, which included the various planning steps identified in the SAMHSA FY 2012-2013 Block Grant Application guidance and the block grant spending plan. The Committee commented on the importance for the language to reflect MHA's commitment to recovery and resiliency throughout the document. They were satisfied that these concepts were emphasized along with priorities of wellness, prevention, and cultural competence in all areas. The Committee was pleased to read of efforts that promote behavioral health integration and of current collaborative activities of the mental health, substance use and developmental disabilities administrations. Additional discussions to be addressed within the application included:

- The description of the various workgroups of the Governor's Commission on Suicide Prevention
- Discussion on programs across the state that focus on the needs of the Latino community
- Passage of an increase in the state's sales tax on alcohol with the hope that the Governor will continue his plans to dedicate future proceeds toward behavioral health needs

In summary, the Joint Council commends the work of the MHA staff in placing a priority on the development of a system in which services meet individual needs across the lifespan and in which efforts are coordinated that support recovery and resiliency. We are pleased with the emphasis on consumer participation and direction throughout the PMHS and look forward to Maryland's implementation of Health Care Reform as a way to improve access to care. We have high expectations for the sustainment of successful partnerships which will be strengthened and enhanced through various collaborative efforts, particularly in the areas of services for individuals with co-occurring issues, wellness, and prevention. The Joint Council fully supports the current Mental Health Block Grant Application.

As a mandate of Public Law 102-321, the Maryland Advisory Council on Mental Hygiene/Planning Council submits a report of its review of the FY 2012 State Mental Health Plan and Mental Health Block Grant (MHBG) application to the Council.

PUBLIC COMMENT ON THE STATE PLAN

Each year, official public notice of the State Mental Health Plan, Block Grant application, and Implementation Report is published in the Maryland Register for citizen review. The Register is published two times per month and provides information on state government activities. The notice in the Register also provides information regarding the availability of the documents. Due dates for the application and the implementation report are noted. Comments are requested in writing. Any responses received prior to finalization of documents are considered and incorporated, as appropriate. Comments are also accepted after submission of documents to the federal government. The notice provides the name of a Mental Hygiene Administration contact person and phone number.

The opportunity to comment on the plan is provided at different stages in the state planning process. The most critical stages of this planning process involve the work of the Joint Council discussed in Section O, State Advisory Council. The development of the goals, objectives, and strategies for the annual state plan involves a series of meetings with active participation from key PMHS stakeholders including representatives of consumer and family advocacy organizations, mental health advocacy groups, advisory council for special needs populations, (such as the deaf or hard of hearing, traumatic brain injury), provider organizations, Core Service Agencies, and a wide range of groups, agencies, and individuals serving on the Joint Council. The annual Joint Council review and recommendation is summarized in the CMHS Block Grant review letter that is included as a part of this application.

During this public process, draft copies of the State Plan and key sections of the Block Grant application are distributed, through the Joint Council mailing and e-mail lists, for review and comment. The Planning Committee reviews the final draft of the State Plan and key Block Grant documents during two separate meetings with MHA staff.

Each year, following the adoption of the State Plan, the document is distributed through the Joint Council mailing list consisting of over 200 members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, MHA's Division of Planning provides copies of the State Mental Health Plan to interested parties upon request. The review and comment on the annual Block Grant Implementation Report follows a somewhat similar process prior to the December submission deadline.

MHA's Division of Planning, in collaboration with the Division of Health Management Information Systems, places the approved State Plan on the Department of Health and Mental Hygiene-Mental Hygiene Administration Web site as a vehicle for notification of the availability and/or for wider distribution of the document. We expect this process to engender questions during the year, which will assist with the development of the Plan for the following year.

APPENDIX A



State of Maryland

Advisory Council on Mental Hygiene/Planning Council

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary, DHMH

August 13, 2011

Virginia Simmons
Grants Management Specialist,
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857 (for First Class Mail) 20850 (Overnight Express)

RE: FY 2012 Mental Health Block Grant Application

Dear Ms. Simmons:

As a mandate of Public Law 102-321, the Maryland Advisory Council on Mental Hygiene/Planning Council submits this report of our review of the FY 2012 State Mental Health Plan and Mental Health Block Grant (MHBG) application. This council, referred to as the Joint Council, is composed of consumers, family members of persons with psychiatric disabilities, mental health professionals, representatives of other state agencies, and other interested citizens and is an important source of advice and advocacy in Maryland. In accordance with Section 1915(a) of the Public Health Service Act, this letter includes public comments on the Maryland planning process, forms of advocacy employed by the mental health planning council, and recommendations on the FY 2012 State Mental Health Plan and Mental Health Block Grant Application.

MHA strategies continue to involve effective and efficient collaborations to support sustainability of the advancements of the Mental Health Transformation State Incentive Grant (MHT – SIG) that promote recovery and resiliency. The Joint Council will continue to follow sustainment efforts and closely follow the work of the Maryland Health Care Reform Coordinating Council as it makes policy recommendations that will ensure efficiency in implementing affordable and cost efficient health care to Maryland.

c/o Mental Hygiene Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473

TDD for Disabled – Maryland Relay Service (800) 735-2258

Healthy People in Healthy Communities

The Joint Council is pleased to report that despite the challenges the state and national governments face economically, which have dramatically reduced state tax revenues, state leadership has maintained access to services in the Public Mental Health System. The number of consumers served by the PMHS has reached more than 129,000 and changes in Medicaid and federal initiatives such as the Residential Treatment Centers (RTC) Waiver have expanded eligibility, and resulted in increases in the need for inpatient services as well as community mental health services. This February we testified concerns at both MHA budget hearings that: "the previous level of funding may not provide enough resources to serve projected increases in numbers of persons with mental illness in our state with increasing MA enrollment and improved access through health care reform". This fiscal year, the Joint Council will continue to emphasize the importance of maintaining a focus on more efficient community services and maintaining resources without raising the average cost of services per consumer.

Our Joint Council meets monthly with our Mental Hygiene Administration (MHA) Director and key agency staff. During FY 2011, the Joint Council kept track of the progression of events within the PMHS through reports from the Executive Director of MHA and through various presentations of activities surrounding, family, and children's initiatives including:

- Activities of system's change such as the Executive Director's presentation on Health Care Reform
- Reports on service initiatives such as trauma-informed care, forensic services, and housing
- Cutting edge studies such as the Research on intervention outcomes After Initial Schizophrenia Episodes
- updates from MHA Office of Consumer Affairs and from DHMH Deputy Secretary of Behavioral Health and Disabilities and agency presentations on mutual projects that support mental health initiatives
- New projects such as the Parity Project and the Senior Health Insurance Program,
- Legislative reviews

Joint Council members, either as Council representatives or in their organizational capacities, also serve on numerous task forces and workgroups. In FY 2011, this included participation on Medicaid Long-Term Care taskforce, the Mental Health Coalition, and the Workforce Steering Committee among others. Additionally, as mentioned above, the Joint Council provided testimony on MHA's budget at hearings before key Committees of the State Legislature.

The Joint Council is actively involved in the development of the State Mental Health Plan and the Federal Mental Health Block Grant Application. The Planning Committee is now monitoring public mental health system data and participating in the State planning process year round. In 2011, a series of Planning Committee meetings were held to develop and review the FY 2012 State Mental Health Plan and prepared for the MHA public meeting on April 29, 2011 to develop the FY 2012 State Mental Health Plan. This year the public meeting included broader participation of representatives in the area of behavioral health and substance abuse. More than 75 representatives of mental health advocacy organizations, wellness and recovery centers, Core Service Agencies (CSAs), local mental health advisory committees, representatives from the Alcohol and Drug Abuse Administration (ADAA) and members of the MHA Management Committee attended. On June 21st, the Committee met to review a draft of the Goals, Objectives, and Strategies for the FY 2012 Plan and modified, expanded, and strengthened the strategies as appropriate.

On July 19th, the full Maryland Advisory Council on Mental Hygiene/ PL 102 – 321 Planning Council received the report of the Planning Committee members and recommended the adoption of the FY 2012 State Mental Health Plan along with the following comments:

- Continue to support school-based mental health efforts
- Address the need to further reduce the impact of homelessness for individuals with mental illness. At the same time, the Council continues to encourage and support interagency efforts to promote a range of housing and residential options in Maryland. The availability of affordable housing remains a particularly critical need for consumer independence and recovery
- Continue the partnerships with state and local entities with increased input such as trend analysis and examination of needs assessments from local entities into the statewide planning process
- Continued attention to workforce development needs including recognition of gaps in the workforce that provides services to the mental health and substance abuse (co-occurring) treatment population
- Promote efforts toward wellness and prevention issues such as smoking cessation. We support MHA's focus on smoking cessation as a key response to disparities in mortality rates for people with mental illness
- Continued advancement of efforts to address co-occurring issues and service needs
- Follow closely the partnership of the mental health and the substance abuse administrations on levels of data, function, and policy

Also, the Planning Committee made recommendations to enhance the document such as: adding examples to data utilization and social networking strategies, including a wider base of youth leadership as involve parties in strategies that addressed public education and training and TAY issues, recognizing appropriate involved parties to many strategies, and pinpointing the appropriate populations for specific trainings.

On July 26th the Planning Committee held an additional meeting to review key sections of the FY 2012 Federal Block Grant Application, which included the various planning steps identified in the SAMHSA FY 2012-2013 Block Grant Application guidance and the block grant spending plan. The Committee commented on the importance for the language to reflect MHA's commitment to recovery and resiliency throughout the document. They were satisfied that these concepts were emphasized along with priorities of wellness, prevention, and cultural competence in all areas. The Committee was pleased to read of efforts that promote behavioral health integration and of current collaborative activities of the mental health, substance use and developmental disabilities administrations. Additional discussions to be addressed within the application included:

- The description of the various workgroups of the Governor's Commission on Suicide Prevention
- Discussion on programs across the state that focus on the needs of the Latino community
- Passage of an increase in the state's sales tax on alcohol with the hope that the Governor will continue his plans to dedicate future proceeds toward behavioral health needs

In summary, the Joint Council commends the work of the MHA staff in placing a priority on the development of a system in which services meet individual needs across the lifespan and in which efforts are coordinated that support recovery and resiliency. We are pleased with the emphasis on consumer participation and direction throughout the PMHS and look forward to Maryland's implementation of Health Care Reform as a way to improve access to care. We have high expectations for the sustainment of successful partnerships which will be strengthened and enhanced through various collaborative efforts, particularly in the areas of services for individuals with co-occurring issues, wellness, and prevention. The Joint Council fully supports the current Mental Health Block Grant Application.

Sincerely,



M. Sue Diehl
Chairperson

cc: The Honorable Martin O'Malley, Governor
Joshua M. Scharfstein, Secretary, DHMH
Renata Henry, Deputy Secretary, Behavioral Health and Disabilities, DHMH
Brian Hepburn, M.D., Executive Director, MHA

APPENDIX B

FY 2012 MENTAL HEALTH BLOCK GRANT (MHBG) SPENDING PLAN

At the submission of this application, States are instructed to submit their FY2012 applications based on the FY 2011 State Allotments. Maryland's current allotment is \$7,336,336. This amount may change (increase or decrease). Once final appropriations are available, States will not be required to submit modifications unless the change in allotment significantly affects the State Plan submitted and approved by CMHS.

The FY 2012 Block Grant allocation spending plan includes implementation of evidence-based and best practice models, efforts in the area of crisis response systems and a continuation of some historically funded programs. A few programs were retooled in ways that will now allow them to garner fee-for-service system reimbursements.

The following chart provides information on the programs to be funded and the annualized amounts to be awarded to the CSAs, the University of Maryland, and MHA Headquarters to carry out the block grant funded activities. Program funding of \$7,186,839 and administrative costs of \$149,497 are included in this spending plan. Services for children and adolescents are highlighted in bold italics.

Services for children and adolescents are 22% of the total allocated program funding. Services for adults only constitute 35% of the funding. Services that include children, adolescents, and adults constitute the remaining 43% of the total allocated program funding.

FY 2012 Mental Health Block Grant Spending Plan – List of Award Entities

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY*
ALLEGANY COUNTY Allegany County Mental Health Systems Office P.O. Box 1745 Cumberland MD 21501 Lesa Diehl	76,242	ALLEGANY COUNTY MENTAL HEALTH CLINIC – support and maintain three crisis/respice care homes to be available to therapeutic foster care families and regular providers of foster care.	75 respice days, 1 crisis day 196 outings 20 hrs. training
		CSA – provide supports (e.g., special programming, furniture) to enhance efficacy of medical/clinical interventions when person is experiencing stressor/episode requiring out of the ordinary intervention to maintain stability and divert from more restrictive intervention.	100 consumers
ANNE ARUNDEL COUNTY Anne Arundel County Mental Health Agency P.O. Box 6675, MS 3230 1 Truman Pky, Ste 101 Annapolis MD 21401 Frank Sullivan	1,194,000	AFFILIATED SANTE GROUP, INC. – to operate a county-wide comprehensive crisis system for all age groups. Funds will support an urgent care psychiatric center; 24 hour/day, 7 days/week single point of access and repository (Networks of Care), information and referral telephone line; 6 mobile crisis teams on varying shifts, 7 days/week to work with both police and other emergency calls; in-home intervention service availability; outreach to homeless 1 shift/day, 6 days/week; transportation; emergency housing; and crisis response training for emergency responders and system users.	500 urgent evaluations 16800 telephone calls 1872 mobile crisis calls 72 in-home visits 40 homeless clients 120 persons transported 100 bed days of emergency housing 12 trainings

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
BALTIMORE CITY Baltimore Mental Health Systems, Inc. 201 East Baltimore Street Suite 1340 Baltimore MD 21201 Jane Plapinger	1,057,939	BLACK MENTAL HEALTH ALLIANCE – provide case-finding, family support, educational programs, information and referral for family members of persons with serious mental illness in the African-American community.	225 families
		PROJECT P.L.A.S.E. – purchase of shelter bed days for individuals who are homeless and have a serious mental illness through a shelter program experienced with this population. Service contracted as a city-wide service. Funding allows for purchase of 4 beds, 365 nights per year.	12 people
		BALTIMORE CRISIS RESPONSE, INC. (BCRI) – partial funding of 24-hour hotline service and 5 mobile crisis outreach teams, operating 8am-8pm daily.	1200 individuals 10000 calls
		UNIVERSITY OF MARYLAND MEDICAL SYSTEMS –to provide funding for components of a program for persons with mental illness and substance abuse. Staff person to coordinate services within OMHC, staff training, use of specialized instruments, train other providers.	50 consumers
		HARFORD BELAIR COMMUNITY MENTAL HEALTH CENTER – Staff person to coordinate services within OMHC, staff training, use of specialized instruments.	50 consumers
		VILLA MARIA – BALTIMORE CHILD AND ADOLESCENT RESPONSE TEAM (BCARS) – <i>to support, in part, a comprehensive psychiatric crisis service for children and adolescents, which includes a crisis hotline, mobile crisis services, in-home intervention services, enhanced support and supervision services, and residential crisis services.</i>	<i>Hotline – 1000 calls/year</i> <i>Mobile crisis – 2 teams, M – F, 9:30 am – 8pm 650 served</i> <i>in home team – up to 8 referrals per week</i>

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
		MEDICAL SERVICES OF THE CIRCUIT COURT OF BALTIMORE CITY – infrastructure support (staffing) to assure timely processing of referrals for mental health assessments for post adjudicated children and youth, at the request of DJS or Juvenile Court	1 FTE program coordinator 1 FTE Administrative Assistant
		BMHS – funds to contract with private vendors for systems evaluation/evidenced-based practices projects to be performed on behalf of the MHA and CSAs. Projects will be identified collaboratively among MHA, CSAs and the University of Maryland Mental Health Systems Improvement Collaborative. The Collaborative will be responsible for specifications for tasks and monitoring/oversight of projects and vendors.	N/A
BALTIMORE COUNTY Baltimore County Department of Health Bureau of Mental Health Third Floor 6401 York Road Towson MD 21204 Robert Blankfield	368,366	AFFILIATED SANTE – to fund 24-hour point of contact telephone line portion of a comprehensive crisis system, community education and awareness.	1200 calls/year – c&a 8000 calls/year – adult 50 community and education contacts
		THE MENTAL HEALTH ASSOCIATION – Peers Program – a volunteer, outreach, support, education and advocacy program focusing on consumers aged 65 and over to complement rendered treatment services and prevent post-treatment decline.	70 groups – 1460 people 60 clients – 1200 visits
		VILLA MARIA – an after-school intervention program providing a structured setting with intensive therapeutic services to children, ages 6-13 in the Lansdowne area.	35 children 2736 sessions

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
CALVERT COUNTY Calvert County Mental Health Department P.O. Box 980 Prince Frederick MD 20678 Douglas Weems	78,237	HEALTH DEPARTMENT – operate a mobile geriatric mental health service, providing consultation, assessment and direct services at locations in the community–senior centers, homes, nursing homes.	80 individuals per year
CARROLL COUNTY Carroll County Core Service Agency 290 South Center Street, Box 460 Westminster MD 21158-0460 Sarah Hawkins	10,000	Provide a Family – Psycho Education coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals.	10 families/year participate 90% of eligible families contacted for participation
CECIL COUNTY Cecil County Mental Health Department 401 Bow Street Elkton MD 21921 Gwen Parrack	190,000	UPPER BAY COUNSELING & SUPPORT SERVICES – <i>provide funds to an integrated system of children's school-based services. Funds used for liaison case management, classroom observation, consultation, team meetings, crisis response and specialty groups, transportation, interagency collaboration.</i>	<i>70 observation hours</i> <i>925 consultations</i> <i>50 crisis consults</i> <i>450 pupil personnel mtgs</i> <i>60parent/teacher mtgs</i> <i>25 ARD mtgs</i> <i>135 students in groups</i> <i>4975 student transports</i>

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
CHARLES COUNTY Charles County Human Services Partnership 4545 Crain Highway P.O. Box 1050 White Plains MD 20646 Karyn Black	130,000	<i>Transitional program for youth, aged 16+, with dual diagnoses of mental health and substance abuse disorders. Funds to be used to support housing and increasing levels of independent living.</i>	<i>8 youth/year</i>
FREDERICK COUNTY Mental Health Management Agency Suite 8 22 S. Market Street Frederick MD 21701 Robert Pitcher	131,236	WAY STATION – to provide mobile crisis availability and services.	75 contacts 1pm – 11pm, 7 days/wk
		BEHAVIORAL HEALTH PARTNERS – Provide a Family – Psycho Education coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals.	10 families/year participate 90% of eligible families contacted for participation
		FREDERICK COUNTY MENTAL HEALTH ASSOCIATION – to provide additional support for hotline operation to better coordinate with other crisis services.	9000 calls total

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
GARRETT COUNTY Garrett County Core Service Agency 1025 Memorial Drive Oakland MD 21550 Fred Polce, Jr.	40,000	GARRETT COUNTY OUTPATIENT MENTAL HEALTH CLINIC – to provide mental health services, case management to students and consultation to school personnel in alternative school programs.	40 IEP mtgs 10 behavioral plans 60 mental health education sessions m.h. support services to 150 students 20 consults to behavior support teams
HARFORD COUNTY Core Service Agency Suite 201 206 South Hays Street Bel Air MD 21014 Sharon Lipford	170,000	HARFORD COUNTY HEALTH DEPARTMENT – operate a year-round diversion program day treatment as a joint effort of the county's public school system and mental health center. The program targets middle and high school aged youth who are in need of a short-term level of intensive intervention and who otherwise would be candidates for hospitalization or residential treatment placement.	24 youth (8 students at anytime)
HOWARD COUNTY Howard County Mental Health Authority Suite 150 9151 Rumsey Road Columbia MD 21045 Donna Wells	280,400	SHEPPARD PRATT OUTPATIENT MENTAL HEALTH CLINIC – provide outreach services to families with children and adolescents who are at risk for out-of-home placement or returning from an out-of-home placement. Outreach is utilized to engage families until they are able to utilize more traditional services. CONSUMER QUALITY TEAM-CQT –to improve quality oversight of the pmhs by recording and addressing individual consumers' satisfaction with the services received.	20 families per year

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
MID-SHORE MENTAL HEALTH SYSTEMS, INC. 28578 Mary's Court Suite 1 Easton MD 21601 Holly Ireland	54,999	FORENSIC MENTAL HEALTH- Provide forensic mental health assistant with the coordination of mental health services in court systems in five rural counties to develop and implement jail diversion efforts.	Individuals assessed and referred for diversion plans.
MONTGOMERY COUNTY Department of Health and Human Services 401 Hungerford Drive 5 th Floor Rockville MD 20850 Raymond Crowel	569,787	ASSOCIATED CATHOLIC CHARITIES – transitional shelter program for homeless adult men with mental illness.	5037 bed days (15 residents)
		MONTGOMERY COMMUNITY RESIDENCES – transitional shelter program for homeless adult women with mental illness.	2686 bed days 8 consumers
		MONTGOMERY DHHS OMHC – Provide an FPE coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals	10 families/year participate 90% of eligible families contacted for participation
		THRESHOLDS, INC. – Provide a Family – Psycho Education coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals	10 families/year participate 90% of eligible families contacted for participation
		ST. LUKE'S – Provide a Family – Psycho Education coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals	10 families/year participate 90% of eligible families contacted for participation
		CORE SERVICE AGENCY – 2 FTE's to conduct mh assessments/consults for mh/sa treatment and/or support services for children referred by DJS, child welfare and other community sources.	80 children/month assessed children referred to f/u treatment, as needed

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
PRINCE GEORGE'S COUNTY Prince George's County Government Department of Family Services Mental Health Authority Division Harriet Hunter Building 6420 Allentown Road Camp Springs MD 20748 L. Christina Waddler	1,338,321	AFFILIATED SANTE GROUP – to provide crisis services, including 24 hours/day, 7 days/week single point of access through hotline/operations center (triage and resource management) 16 hours/day, 7days/week; crisis screening thru Prince George's hotline 8 hours/day, 7 days/week; mobile crisis response team 2 shift/day, 7 days/week; access to urgent care appointments; in-home intensive family intervention; transportation; temporary housing; CISM training; and coordination of disaster services.	2,400 triage calls/year 5,000 crisis calls screened/year 65 mobile crisis interventions/month availability of 150 urgent care psychiatric appts and 312 urgent care evening and weekend appointments per year 120 families/year 60 rooms/year 104 transports/year 50 prescriptions/year
		NORFIELD ACRES II, INTEGRATED HEALTH SERVICES AND THE CASTLE OF LOVE – residential and intensive 24-hour/day support services for psychogeriatric residents.	Norfield – 2 consumers Integrated Health – 1 Consumer Castle – 4 consumers
		VOLUNTEERS OF AMERICA – purchase psychogeriatric services of registered nurse and nursing assistants to support residential placement of ten elderly consumers.	10 people

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
WICOMICO COUNTY 108 East Main Street Salisbury MD 21801 Heather Brown	77,800	WICOMICO COUNTY HEALTH DEPARTMENT – Minority Youth Mental Health Outreach Project – provide outreach in 5 counties to community agencies/families/clients/faith organizations, particularly minority communities, to increase understanding and reduce the stigma of receiving mental health services.	<i>4 parent-youth focus groups-25 people/group</i> <i>4 presentations to the faith community-25 persons/group</i> <i>quarterly meetings Advisory Board</i> <i>Resource library available</i> <i>Annual conference held</i> <i>Youth Council Advisory meetings quarterly</i>
		LOWER SHORE CLINIC – Provide an Family – Psycho Education coordinator within the OMHC to coordinate groups, provide outreach to families and referral sources, supervise/oversee mh professionals	10 families/year participate 90% of eligible families contacted for participation
WORCESTER COUNTY Worcester County Core Service Agency US 113 & St. Hwy 365 P O Box 249 Snow Hill MD 21863 Jennifer LaMade	335,338	WORCESTER COUNTY HEALTH DEPARTMENT – provide crisis response system for total county, including two mobile crisis teams available 24 hours/day, 7 days per week. Additional resources included for summer months for unit for Ocean City (a resort area), linked to police, other health department and <i>juvenile justice services</i> . Services to be provided to all ages, <i>with particular emphasis on the increased youth population between May and September.</i>	350 interventions/ year

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION

FUNDED ENTITY	12 MONTH FUNDING	PROJECT DESCRIPTION	CAPACITY
UNIVERSITY OF MARYLAND, SCHOOL OF MEDICINE, DEPARTMENT OF PSYCHIATRY Suite L 1501 South Edgewood, Baltimore MD 21227 Howard Goldman, M.D.	1,084,174	MENTAL HEALTH SYSTEMS IMPROVEMENT COLLABORATIVE – fund infrastructure (e.g. staff) to operate Systems Evaluation Center (SEC) and Evidence-Based Practice Center (EBPC). The SEC will design system/program evaluation activities, analyze data, and assist in identification of effective practices, appropriate performance/outcome indicators, etc. The EBPC will disseminate and train programs in implementing evidence-based practices.	N/A
MENTAL HYGIENE ADMINISTRATION HEADQUARTERS Spring Grove Hospital Center 55 Wade Avenue – Dix Building Catonsville MD 21228 Brian Hepburn, M.D.	149,497	ADMINISTRATIVE EXPENSES – 1 staff position, travel, equipment, contracts, conferences, etc.	

APPENDIX C

FY 2012 – 2013 MARYLAND MENTAL HEALTH BLOCK GRANT

Mental Hygiene Administration Liaisons to Maryland State Government Agencies											
Maryland Department of Disabilities (MDOD)	Governor's Office for Children (GOC)	Governor's Office of the Deaf and Hard of Hearing (ODHH)	Maryland State Department of Education (MSDE)	Division of Rehabilitation Services (DORS)	Department of Human Resources (DHR)	Department of Housing and Community Development (DHCD)	Maryland Department of Aging (MDoA)	Department of Public Safety and Correctional Services (DPPSCS)	Department of Juvenile Services (DJS)	Department of Veterans Affairs	Judiciary of Maryland
Brian Hepburn, M.D.	Al Zachik, M.D. Tom Merrick and Marcia Andersen	Marian Bland	Al Zachik, M.D. Cyntrice Bellamy	James Chambers and Steve Reeder	Daryl Plevy, Al Zachik, M.D. and Marian Bland	Penny Scrivens and Marian Bland	James Chambers and Marge Mulcare	Larry Fitch and Marian Bland	Al Zachik, M.D., Cyntrice Bellamy, Larry Fitch and Lynn Edwards	Marian Bland	Larry Fitch and staff
Mental Hygiene Administration Liaisons to Maryland State Government Agencies											
DHMH Alcohol and Drug Abuse Administration (ADAA)	DHMH Family Health Administration (FHA)	DHMH Developmental Disabilities Administration (DDA)	Maryland Health Care Commission (MHCC)	Health Services Cost Review Commission (HSCRC)	The Children's Cabinet	DHMH Medical Care Programs (Medicaid)	DHMH Office of Health Care Quality (OHCCQ)	DHMH Office of Capital Planning, Budgeting, and Engineering Services	DHMH AIDS Administration	Maryland Emergency Management Administration (MEMA)	
Carole Frank and Pat Miedusiewski	Al Zachik, M.D.	Stefani O'Dea, Lisa Hovermale, M.D. and Debra Hammen	Brian Hepburn, M.D.	Brian Hepburn, M.D.	Al Zachik, M.D.	Brian Hepburn, M.D., Daryl Plevy, Gayle Jordan-Randolph, M.D., and Melissa Schober	Sharon Ohlhaber	Cynthia Petion and Robin Poponne	Marian Bland	Arlene Stephenson	

ⁱ MHA Annual Report, Fiscal Year 2010

ⁱⁱ MCF Newsletter

ⁱⁱⁱ Excerpted from Barbara Mauer, “Integrating Behavior Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities,” 2005.

^{iv} Mental Health Transformation State Incentive Grant – Inventory of Resources/Needs Assessment Report – September 2006, Prepared by: University of Maryland, Baltimore, Systems Evaluation Center